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‘Fertility treatment among ‘older’ women: a qualitative review’

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A thesis submitted to the University of Huddersfield in partial fulfilment of  
the requirements for the degree of Master of Science by Research

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## **Abstract**

The emergence of fertility treatments has not only given some infertile women the ability to have a biological child; they have also given women more choice regarding their reproductive timing. The recent 'trend' to 'delay' motherhood has increased the demand for infertility services. However, the increase in 'older mothers' (women who begin their families at or over the age of thirty-five) who access fertility treatments has caused concern for health professionals. Informed by a phenomenological epistemology which was guided by a feminist viewpoint, this research explored the views and 'lived experiences' of women over the age of thirty-five who access fertility treatments. Contemporary literature predominantly focuses on the medical implications of fertility treatments and does not take into account the context in which the social experience takes place, or the meaning that people assign to this experience. Therefore the central aim of this research was to increase understanding of 'older' women's motivations for utilising fertility treatments and to examine these women's lived experiences of undergoing treatment to have a child. The research objectives were to explore why women over thirty-five consider fertility treatments; to investigate women's views on fertility treatments; and to locate the findings in context of discourses of contemporary motherhood. In order to address these, a qualitative methodology was applied. Methods included in-depth telephone interviews to investigate the perceptions of ten women aged thirty-five and over, who accessed fertility treatments to support conception. The use of semi-structured interviews allowed the participants to discuss their experiences and express their views in-depth, thereby providing the opportunity to explore and understand the topic from a unique stance.

Fertility treatments used by 'older' women are often viewed as negative. A 'selfish' label may be applied to the women, as it is presumed that they are responsible for 'choosing' to delay motherhood and increasing risk to themselves and their unborn child. However, the 'older' mothers in this study did not identify with this representation, as none of them postponed motherhood by choice. This research captures an in-depth understanding of 'older' women's who view assisted reproductive technologies very highly. Cultural and gender expectations which are underpinned by pronatalism, influenced the women's decision to have treatments. Significantly, the study makes a contribution to current literature surrounding the motivations, experiences and perceptions of women over thirty-five who undergo fertility treatments.

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## Abbreviations

It is of particular importance to address the abbreviations of terminology used within this thesis.

**In-vitro fertilisation (IVF)** – During this process, an egg/s is removed from the women's ovaries and fertilised with sperm in a laboratory. The fertilised egg (called an embryo) is then returned to the women's womb to grow and develop.

**Assisted reproductive technology (ART)** – Reproductive technologies used to achieve pregnancy.

**The National Institute for Health and Care Excellence (NICE)** – An executive non-departmental public body of health in the United Kingdom. It provides national guidance and advice to improve health and social care.

**The National Health Service (NHS)** – A publicly funded healthcare system for England.

**Human Fertilisation and Embryology Authority (HFEA)** – Dedicated to licensing and monitoring fertility clinics and all research involving human embryos within the United Kingdom. They provide impartial and authoritative information to the public.

## **Chapter One - Introduction**

Over the years there has been a large increase in infertile women utilising fertility treatments to assist with their reproduction. In 1992, only 14,057 women received in-vitro fertilisation (IVF) or Intra-cytoplasmic sperm injection (ICSI) treatment, compared to 47,422 women in 2012 (Human Fertilisation and Embryology Authority, 2013). This reflects the greater availability for fertility treatments, as within twenty years there was over three times as many women undergoing treatment. Infertility and the increase use of fertility treatments are heavily focused topics within the media and they are overwhelmingly linked to the age of the women. There is a presumption within society that ‘older’ women utilise fertility treatments as a result of leaving motherhood until later in life (Boivin et al, 2009). However, there is little quality evidence which justifies this is the case. There is a large body of research addressing the health (Bay, 2013) and financial implications (Katz, 2011) of fertility treatments; however, the social aspects, women’s views and actual lived experiences are under-represented within existing literature of fertility treatments (Schiebinger, 2003). Therefore this gap in existing literature was the motive for carrying out this particular study and is the reason why this it is fundamental.

The aim of this research therefore is to explore the views and experiences of fertility treatments among women over the age of thirty-five. From a biological perspective, thirty-five is a significant age for infertility and fertility treatments because it is proven that the probability of conception falls rapidly from this age with an increase risk to both the mother and baby during pregnancy and birth (National Institute for Health and Care Excellence, 2013). Despite there been contention over the exact definition of older motherhood (Carolan et al, 2013), the medical profession define the older mother as pregnant at the age of thirty-five or older (National Institute for Health and Care Excellence, 2013). Interestingly however, seemingly undeterred or unaware of the growing concern for ‘older’ mothers within the medical profession, the average age of a woman seeking fertility treatments is thirty-five (HFEA, 2013). This average age has increased by two years since 1992 and it reflects the general trend in the United Kingdom (UK) and elsewhere, for women to have children later in life. As the use of fertility treatments among ‘older women’ is a controversial issue in which many women have strong opinions, it felt necessary to have women’s experiences and perceptions at the heart of this study as well as to guide the findings of this research.

In order to ‘set the scene’ for this research project, the following section will begin by examining the extent in which motherhood is a desired social role. In order to effectively investigate women’s experiences of fertility treatments, it is crucial to understand the social norms of motherhood and childbearing, to give an insight into the reasons why infertile women desire to have biological children. As motherhood is central to contemporary gendered expectations for women, society exerts structural and ideological pressures upon women to become mothers (Ridgeway and Correll, 2004). The extent in which contemporary discourses of motherhood effects women’s views and experiences of infertility treatments will therefore be explored.

This thesis will be structured into individual chapters, each with a specific purpose. Chapter Two will be devoted to contextualising the topics which underpin fertility treatments and the women who utilise them. The chapter begins with a critical review of existing literature around motherhood and explores contrasting views of the extent in which childlessness is becoming more socially acceptable in western societies. These theories are then developed and a woman’s ‘choice’ to postpone motherhood is examined before exploring ‘older mothers’. Societal issues around the use of fertility treatments and the risks associated with them are also debated, thereby informing the theoretical basis for the research and to understand the nature of the chosen topic area. Chapter Three will be dedicated to the methodological approaches utilised. The theoretical framework is explained, giving an in-depth understanding of thematic analysis with which the data collected for this research was examined. The methods and techniques used are also illustrated within this section. Chapter Four is dedicated to an analysis of the data, taken from ten semi-structured telephone interviews with women over the age of thirty-five. The findings from the data are discussed and new areas of knowledge are drawn together and represented in context of the literature, in chapter Five. Finally, chapter Six is allocated to the conclusion where a summary of the main findings will be documented and the limitations and recommendations of the study will be explained.

## **Chapter Two – A Review of the Literature**

This chapter will be dedicated to outlining existing literature and relevant critiques will be made in order to provide a wider context within which this research sits. Discourses of motherhood and the belief that women internalise pronatalist values will initially be discussed to set the scene for following topic areas. Pronatalists encourage reproduction and perpetuate the belief that a woman's primary social role is to become a mother and experience motherhood (Parry, 2005). Following this, additional areas of literature will be discussed including: the timing of motherhood which addresses the notion of 'good' mothering and the ideology that 'older' mothers are deviant; infertility and involuntary childlessness and finally, delaying motherhood and the biological clock. Theoretical perspectives around the medicalisation of fertility treatments and the risks associated with them will also be reviewed, with emphasis on feminism and their contributions and understandings of women who utilise assisted reproductive technologies (ART). A conclusion will then be drawn upon to evaluate the literature, display the main findings and highlight any gaps.

It is imperative to highlight that the generalisations used within this chapter and the following chapters are informed by the literature and do not necessarily reflect the researchers personal view; and not all of the discussions reflect today's diverse cultures and populations.

### **2.1 Pronatalism and Motherhood**

Pronatalist ideology embodies the belief that a woman's worth is tied to conceiving and bearing children (Ulrich and Weatherall, 2000). Pronatalists believe that becoming a mother is imperative as a couple cannot be seen as 'normal' if they do not have children (Parry, 2005). It is believed therefore that children strengthen a marriage and are necessary for the well-being of the woman (Parry, 2005). This ideology results in an enormous amount of pressure on women to bear children, which can be particularly distressing for women with infertility problems (Park and Hill, 2014). Although some may suggest pronatalism is an outdated view, our society still has pronatalist values embedded in our consciousness, culture, beliefs and values (Carroll, 2012). For some, pronatalism is believed to be the 'norm', and like other norms we learn early in life what is expected; and in this case, becoming a mother still remains something in which women are expected to conform (Carroll, 2012).

'Motherhood' is commonly associated with the transition from being a childless women to becoming a woman who experiences giving birth and raising a child (Fairclough, 2004).

Although the practices and ideas vary in accordance to socio-historical and cultural contexts, motherhood is a natural instinct which derives from a woman's biological nature (Dedeoglu, 2006). In opposition to the overwhelming amount of discourses on motherhood which suggest that to be a mother is rooted in biology, feminists believe that what we commonly view as a 'maternal instinct' is actually a socially constructed phenomenon, which is embedded in society's norms and expectations (Varada, 2011). Furthermore, the idea that motherhood can be 'performed' differently and is historically, culturally and socially relative echoes the idea that the existence of motherhood is socially constructed (Glenn, 1994). Motherhood, whether biologically rooted or socially constructed is an identity discourse in that it provides a primary identity for adult women, therefore reinforcing their gender identity (Varada, 2011).

## 2.2 Voluntary and involuntary childlessness

Within Western societies, there has been an increase in women having their first child later in life or opting out of parenthood altogether (Jarvie et al, 2015). Choosing not to have children tends to place women outside the constraints of socio-cultural expectations and causes them to deviate from cultural norms; particularly those which are underpinned by pronatalism (Doyle et al, 2012). Women who choose not to become mothers are viewed by pronatalists as challenging this 'natural' role and rejecting the crucial element which constructs feminine identity (Mollen, 2006). As a result, women do not often discuss the decision to have children; rather they see it more as a matter of timing; as voluntary childlessness (despite being an option) has always been viewed as a 'deviant group' (Morison, 2013).

Despite this, there is a controversial presumption in society that all childlessness is voluntary and those women, are childless as a result of their own 'selfish' choice (Lee and Gramotnev, 2006). The transition to parenthood however, is disrupted for nine to fifteen percent of the population who encounter infertility (Boivin et al, 2011). New (2013, cited in NICE, 2013: P9), defines infertility as being 'a woman of reproductive age who has not conceived after one year of unprotected sexual intercourse'. After thorough examination and treatment, about three to five percent of those couples who wish to have a child, cannot have biological children (Kraaij, 2009). Although some couples fulfil their wish to have a child in other ways, such as adopting or becoming a foster parent, others choose not to pursue any other options as they believe that there is no solution to their infertility problems (Kraaij, 2009). Conversely, Bell (2013) argues that not all involuntary childless women are infertile, as

women who want children but are not in a stable relationship may attempt to conceive children through assisted conception (Letherby, 2013). Furthermore, women may be prevented from having children if they or their partner is a carrier of a genetically inherited disease or the women may choose against pregnancy if she herself is HIV-positive (Letherby, 2010). This section of the literature review will, however, focus on involuntary childlessness as a consequence of infertility, as it is in line with the research concept.

There are two types of people who experience involuntary childlessness as a factor of infertility; those who are under treatment for their infertility and have therefore still not come to accept their childlessness as a definite fact, and those who are no longer treated for infertility anymore and consider themselves as definitely childless as they are unable to have a biological child (Gurunath et al, 2011). Greil (2009) argues that the infertility experience is predominantly negative and dominant themes identified by involuntary childless women include negative identity, a sense of worthlessness and inadequacy, a feeling of lack of personal control, anger and resentment, anxiety and stress, lower life satisfaction and envy of other mothers. These women are also likely to have higher levels of distress and be psychologically affected by their inability to fall pregnant because it is a normative life expectation for women which shapes their identity and life experience (Pandian and Bhattacharya, 2013). Infertility is often regarded as a deviation from social norms and the stigma attached to this deviation is particularly potent for women who are much more bound by societal expectations with regard to family and motherhood (Bell, 2013). Quinn and Chaudior (2009) similarly argue that women who value motherhood but cannot fulfil the role themselves are likely to have greater concerns about childlessness, than women who value motherhood less. Involuntary childless women are likely to value motherhood highly and put pressure on themselves to have children because they may have idealised images of what motherhood will be like (McQuillan et al, 2008).

When studying what childless women and women with reproductive problems think of motherhood, Woollett (1991) found three aspects of motherhood which made childlessness difficult: motherhood was seen as mandatory, as an integral part of a 'normal' female identity, and as constituting an opportunity for establishing intimate relationships. However, Dedeoglu (2006) stated that the decrease in fertility rates in England (which according to the Office for National Statistics, had the biggest fall in births in 2013, since 1975) would suggest that women are no longer internalising pronatalist values and although they may still

be pitied by the rest of society, they are no longer seen as a 'deviant group', as more women are 'choosing' to be childless.

Although a considerable amount of literature utilises the term 'involuntary childlessness', a problem with using this term has been identified. 'Involuntary childlessness' does not cover the experience of those medically 'infertile' mothers who are already mothering their biological child/children and wish to have more. Therefore, this term will only be employed in this research in relation to women who wish to have biological children, but currently do not, as a result of external factors.

### 2.3 The older mother

The number of women having children later in life in England and Wales has increased year on year, with a growing number of women having children over 35 (Office for National Statistics, 2013). Nevertheless, dominant ideology promotes 'normative' development, which means that 'older mothers' go beyond our notion of the 'idealised' mother as they challenge the beliefs and expectations of 'good motherhood' (McQuillan and Torres-Stone, 2007). There is inconsistency in the age that defines an 'older mother' as the term is socially constructed, which means the definition fluctuates over time and is something which is open to debate (Boivin, et al, 2009). However, according to Collins and Crosignani (2005), 'older mothers' are generally medically defined as women who have their first child at age thirty-five or over, as this age is associated with changes in obstetrical practice (e.g. increase in prenatal screening). More recent research conducted by Carolan et al (2013), suggests that most researchers still define thirty-five as the age which represents the 'older mother'; with forty-five being defined as the very advanced maternal age. On the other hand, some would argue that there has been a change in the definition of older mothers which has seen a shift in 'older mothers' being defined as women who have their first child at thirty-five, to now being defined as women who have their first child at forty (NICE,2013). However, despite the inconsistencies between definitions, this research views 'older' mothers as those women who have children at or over the age of thirty-five, as it is in line with common societal discourses.

The emerging 'trend' to have children later in life is causing concern for health professionals as not only does a woman's fertility decline with age, but there is also an increase in health risks to the mother and baby (Locke and Budds, 2013). Feminists often ignore the medical complications of having children older and presume that women can choose what and when they want to have a child, as they focus too much on the desire of women rather than what is

considered healthier for her (Cussins, 1996). Statistics favour younger mothers as they show that they are more likely to have safer pregnancies and deliveries than women who postpone motherhood (Lancet, 2014). As a woman gets older, her chance of getting pregnant declines, whilst the chance of miscarriage increases (Maheshwari et al, 2008). Brethrick et al (2012) agree and argue that women over the age of 30 are also more at risk of ectopic pregnancies and chromosomal abnormalities in the baby; the chances of these happening increase when the women is over the age of 35 and the possibility of preterm births and stillbirths also increases. However, on the contrary, several studies on 'older mothers' have found that their experience of pregnancy and childbirth have been positive (Shaw and Giles, 2009). In contrast to younger mothers, 'older mothers' tend to be better prepared, more committed to the 'parenting experience', and less likely to suffer from post-natal depression (Shaw and Giles, 2009). Although, according to Dann (2014), women who delay childbearing may be viewed as 'selfish' because there is an anxiety towards the possibility of the child caring for their elderly parents early in their lives, or even losing their mother at an age where they are still very much dependant on her (Dann, 2014). Furthermore, 'older' mothers are likely to be worried about their energy and coping ability (Shaw and Giles, 2009) and fear missing out on seeing their children grow up (Carolan, 2005). However, dominant discourses of motherhood adopt the ideology of 'good mothering' and recent studies suggest that older mothers have the idealised traits associated with this. Sutcliffe et al (2012) suggested that older mothers are more likely to be caring, have more life experience, be less impulsive and have a calmer disposition, which all appear to be essential for good parenting. In addition, researchers at the institute of Child Health in London found that older mothers make better parents as they are more aware of dangers and potential accidents that children are subjected to (Hope, 2012).

'Older mothers' are presumed to be white, middle class, well educated women who often have occupational responsibilities and higher socioeconomic status (Hammarberg and Clarke, 2005). The stereotypical image of a woman from a middle-class phenomenon was once perceived as an 'ideal mother'; and 'deviancy discourses' of motherhood suggested that 'deviant mothers' were categorised into working-class mothers, teenage mothers, lesbian mothers and black mothers, with unmarried women who are not engaged in paid work but are dependent on public assistance to support their children, being the main spotlight in the discourse (Arendell, 2000). Lancet (2014) suggests that there has been a rise in women from a multiple of socioeconomic and ethnic backgrounds choosing to postpone childbearing but mothers who delay motherhood are still predominately middle-class women. This suggests



that although 'older' white middle class women may challenge discourses of 'good' motherhood, they still remain the 'idealised' mother.

#### 2.4 The 'biological clock' and Infertility

The increase in 'delaying' childbearing until later in life has resulted in an increase in the mean age of giving birth and rising fertility rates among older women (Office for National Statistics, 2013). Statistics show that half of all live births in England and Wales in 2013 were to mothers aged 30 and above, making the average age of mothers increase to 30 years for the first time ever (Office for National Statistics, 2013). In relation to 'older' mothers, the pregnancy rate for women aged 40 and over has nearly trebled since 1991 (a rise in 134%) while for women aged 35-39, fertility has increased by 84% over this period (Office for National Statistics, 2013). There are many explanations as to why there has been an increase in older motherhood, but it is overwhelmingly debated within the topic of women and their increasing involvement in the workforce; and demographic shifts towards delayed parenting has resulted in discourses on the 'biological clock' (Friese et al, 2006). The biological clock is a heterogeneous concept which represents the limited period of time within which a woman can conceive and start a family (Selvaratnam, 2014). The biological clock is a theoretical concept which is based on the simulation between real time and indeterminate variables (the idea that a woman's fertility declines at a different rate to others) and the 'ticking' of the clock represents a woman's decline in fertility (Selvaratnam, 2014). However, as a concept it operates against woman and their free-will to choose when to have a child and emphasises the ideology that a woman's 'choice' to delay childbearing is reduced to biological limitations.

Central to the biological clock discourse, is the notion that higher education and paid work interferes and competes with a woman's fertile years (Friese et al, 2006). There is financial strain for couples in the current climate which pressures women (as well as men) to seek a 'good' income prior to starting a family (Jarvie et al, 2015). However, there is limited research which argues that for some women, their 'biological clock' can also be affected by more complexed issues such as infertility. Berryman and Windridge (1991) acknowledged that existing theories heavily focus on women 'choosing' to delay motherhood and fail to recognise that some 'older' women may not have a choice in the timing of pregnancy due to having fertility problems and/or a lack of an appropriate partner.

Infertility is a public health issue which affects 186 million people worldwide and approximately 3.5 million of those are from the United Kingdom (Inhorn and Patrizio, 2015). According to Talmore and Dunphy (2015), one in seven couples are effected and this rate is on the increase. Although male infertility accounts for at least half of infertility cases globally, infertility is generally seen as a 'women's problem' (Inhorn and Patrizio, 2015). Women usually bear the 'blame' for reproductive failing which can then lead women to experience associated anxiety and grief (Chambers, 2012). This may be a result of the 'social norms' and discourses of motherhood in society, which was previously discussed. However, the stigma of childlessness is most devastating for the less educated women without a career as they are more likely to have familial aspirations (Remennick, 2000).

The causes of female infertility are wide ranging and include diagnoses such as ovulatory disorders, tubal disease, endometriosis and chromosomal abnormalities (Homan et al, 2007). Dechanet et al (2011) state that lifestyle factors such as drinking alcohol, smoking and obesity can also have a negative impact on reproductive performance (Dechanet et al, 2011). However, many cases of infertility are unexplained and the current 'trend' to delay childbearing until the age at which female fecundity is lower, has increased age-related infertility (Maheshwari et al, 2008). Women over the age of 35 are nearly twice as likely to present with unexplained infertility (Panddian and Bhattacharya, 2013) and according to Budds, Locke and Burr (2013), there is common societal discourse which suggests that these women are infertile as result of their own selfishness for 'leaving it too late'. However, Letherby (1999) argues that it is often ignored that some 'older' women may have had previous ongoing fertility problems.

### 2.5 Fertility Treatments and the medicalisation of infertility

Due to the discourses of motherhood and the ideology that women internalise the values and beliefs of pronatalists, women who are involuntarily childless may feel pressured to fulfil their role of a child bearer and choose the option of having fertility treatments to increase their chances of becoming a parent (Schmidt, 2009). 'Fertility treatment' refers to a range of procedures used to assist couples to become pregnant and these treatments vary in methods and intensity (Marino et al, 2010). Infertility was once seen as something which takes away a woman's choice to have a child but the development and medicalisation of infertility treatments has given infertile women more options to fulfil this role (Becker, 1994). In correspondence, Woolett and Boyle (2000) similarly argue that Liberal feminist's writers

would support women to seek medical attention when they are infertile, as they view reproductive technologies as empowering and increasing women's choices. Conrad and Schneider (1980) have used the term 'medicalisation' to denote the process by which certain behaviour comes to be understood as a question of health and illness, subject to the authority of medical institutions. As a society, our lives are increasingly being medicalised and infertility is one phenomenon that is now treated and heavily focused on by the medical community (Inhorn, 2006). Although, radical feminists would disagree with the medicalisation of infertility, as they view infertility as a social problem and argue that the medicalisation of a social problem seems to irritate the problem, rather than finding a solution for it (Forsyth, 2009). Furthermore, such feminists would view assisted reproductive technologies as a way of maintaining a patriarchal system because a woman's reproduction is controlled largely of masculine medical professionals. Radical feminists view fertility treatments as objectifying women because they subject women's bodies and lives to the negative effects of reproductive technologies (Payne and Goedeke, 2007). Although these may be unwanted side effects to the modern way of becoming mothers for some infertile women, Neal (2001) argues that they are virtually unavoidable.

The medicalisation of infertility has meant that there has been a shift in society from childlessness being seen as a social problem to now been viewed as a medical problem; which is a result of women internalising the social norms of womanhood and feeling pressured to have children. In contrast, Forsythe (2009) agrees that infertility has been medicalised and that more women are having treatment, but she argues that society cannot be fully blamed for this as a woman herself is often willing to seek medical advice. However, a woman may not define herself as infertile or seek infertility advice and treatments unless she embraces motherhood as a desired social role (Greil et al, 2010). Therefore rather than a health issue, 'infertility is best understood as a social constructed process whereby individuals come to define their ability to have children as a problem, to define the nature of that problem and to construct appropriate course of action' (Greil et al, 2010: p141).

The medicalisation of infertility began with the development of fertility drugs in the USA in the 1950's and has continued to develop rapidly ever since with the introduction of assisted reproductive technologies (ART) such as in-vitro fertilisation (IVF) and intra-cytoplasmic sperm injection (Geil et al, 2010). Stoop et al (2014) suggests that assisted reproductive techniques are usually the last option for women as they are a range of fertility drugs as a first line approach. Fertility treatments are often suggested by GP's to women who have been

trying to get pregnant for over a year but have not yet conceived (Baird et al, 2005). GP's refer women to fertility clinics when they are concerned that they are infertile or if women are over the age of 35 and struggling to conceive (National Institute for Health and Care Excellence, 2013). The medicalisation of infertility and the development of fertility treatments have provided infertile women an opportunity to increase their chances of getting pregnant, and it is estimated that since 1978 (when the first IVF baby was born), five million babies have been born worldwide following IVF treatments alone (HFEA, 2010). It could be argued that the development of fertility treatments has also given women more 'choice' as to how and when she becomes pregnant. Some women are infertile through no error of their own and others in it assumed undergo fertility treatments as a result on their choice to deliberately postpone parenthood (Smajdor, 2011). However, Stoop (2014) strongly advises that women do not rely on fertility treatments for future use as they cannot compensate fully for the natural decline in fertility with age because there is also an age-related decrease in the chances of fertility with certain treatments. Women aged 30 with no fertility problems will have a 75% chance of conceiving naturally and 66% chance when they are 35 (Campbell, 2014). The chance of getting pregnant declines dramatically within 5 years (between the ages of 30-35), suggesting that women may need medical intervention/fertility treatments to help increase their chances of having a baby (Campbell, 2014). However, the likelihood of becoming pregnant following assisted reproductive techniques such as IVF also reduces as the women gets older, and on average there is a 32.2% chance of a successful pregnancy for women under 35 and a 27.7% chance when the women is aged between 35-37. The success rate decreases rapidly from when the women is 37, with only a 1.9% chance of IVF working for women over the age of 45. Despite the 5% drop in success rates for women below the age of 35 to those 35 and above in 2012, women aged 35 and above utilised fertility treatments the most (HFEA, 2012). This reflects the general trend in the UK to have babies later in life, and since fertility declines with age, it is not surprising that more women over 30 are seeking fertility treatments than ever before (Smajdor, 2011).

## 2.6 The health risks of fertility treatments

Like natural pregnancies, there are many risks associated with having fertility treatments and the risk increases as the women gets older; therefore health professionals are currently under enormous pressure as predominantly it is 'older' women who are having such treatments (Jolly et al, 2000). There is a significant amount of literature which suggests that women who begin motherhood later are putting themselves and their unborn baby at risk (Sutcliffe, 2012).

It is difficult to define the risks associated with fertility treatments as it is an ‘umbrella term’ used to collectively label many individual treatments and each of these have their own risks attached to them (Marino, 2010). Despite this, there are some common risks associated with the use of fertility treatments in general and some may argue that the high risk of multiple births is the single greatest health risk (HFEA, 2015). Having multiple babies increases the health risk of the mother but in particular the unborn babies, as they are more likely to be premature and have low birth weights (HFEA, 2015). In addition, research shows that the risk of death before birth is more than four times greater for twins than a single baby, and the risk increases to seven times greater than a single baby, when having triplets (HFEA, 2015). However, clinics are aware of the increase in risks associated with multiple births and are legally only allowed to implant the maximum of two embryos in the UK with many hospitals and licenced clinics having a ‘one-at-a-time policy’ to minimise these risks (Lord et al, 2001). Statistics show that the ‘one at a time’ campaign to reduce multiple births has had a good impact, with multiple births continuing to decrease. A report shows that multiple births occurred in 16.9% of treatment cycles in 2012, down from 18.8% in 2011 (HFEA, 2014). Conversely, some argue that the biggest risk associated with fertility treatments is the high possibility that the procedure may not work (Brandes et al, 2011). Women may encounter psychological issues when the procedure does not work as it is reinforcing the ideology that they have failed to become a mother and may never be able to live up to the role of a woman (Martin, 2010). In addition, the costs of the treatment are not cheap, and the women/couple can sometimes be left in debt to pay for something that has not worked (Martin, 2010).

Furthermore, Tomao et al (2014) argue that there are several adverse effects related to infertility treatments which affect the women who are undergoing treatment. They suggest that fertility treatments increase the chance of the women having diabetes and argue that there is a correlation between infertility treatments and the development of cancer; in particular breast, uterus and ovarian cancer (Tomao, 2014). However, the risks of infertility treatments are ‘overhyped’ as there are potential risks in every pregnancy (NHS, 2014). The risk of serious complications is twice as high for babies born after fertility treatment, but the risks are still relatively low (NHS, 2014). For instance, the rate of stillbirth is around 1.1% for any assisted conception compared to 0.5% for natural conception (NHS, 2014). This suggests that when having infertility treatment, it is important for the women and often their partner to understand the health and social risks that are attached to the treatment they have chosen. Despite the complications that could happen and the medical risks that could affect the

mother and baby, the chances of having complications are still very low. However, the women who are thinking about having fertility treatments have the decision to risk being childless or risk having fertility treatment and something going wrong.

## 2.7 'Social' risks and the stigma attached to fertility treatments

As well as health risks, there are also 'social risks' associated with women having fertility treatments and women who use them are an emerging topic of motherhood deviancy discourses because such procedures are seen to be interfering with the natural processes of reproduction (Arendell, 2000). The choice to have fertility treatments can perpetuate the social norm of child bearing, which may cause the women to be judged and frowned upon by the rest of society simply because it is the 'norm' to have a baby naturally (Woollett and Boyle, 2000). At the centre of motherhood discourses are the theories that motherhood is biologically driven; and the development of reproductive technologies challenge such theoretical arguments in an attempt to change contemporary cultural understanding of motherhood and to view it as something which is socially rather than biologically defined (Hammons, 2008). Radical feminists are in agreement with the ideology that reproductive technologies could potentially lead to a change in the way society views the role of motherhood (Neal, 2011); as fertility treatments are seen to 'involve the commodification of traditional motherhood as well as reinforcing women's domination by oppressive pronatalist ideologies' (Gimenez, 1991: p337). On the other hand, post-structuralist feminists recognise that a huge positive to assisted reproductive technologies is that they transformed the conventional meaning of reproduction, which has enabled women who are not married to become biological mothers (Michelle, 2006)

Despite the stigmatisation and health risks related to having fertility treatments, women and couples still seek medical advice (Schmidt, 2009). There is a presumption that a woman's motive to seek medical help is driven by gendered expectations and a result of stigmatisation for being childless. In opposition to this ideology, women choose to utilise fertility treatments to have children because they provide potential rewards to their life, such as affection, support in old age, social capital and marital stability (Nomaguchi and Milkie, 2003). Children also present potential costs for women, including time and money, emotional energy and occupational opportunities which means that women make a rational decision to have a child rather than something which has happened as a result of structural and ideological

pressures from society (Sonfield et al, 2013). This suggests that the women's need to have a child outweighs the stigma attached to infertility treatments.

Crowe (1987) carried out a study not long after IVF was introduced. He concluded that many women felt that the stigma attached to infertility and non-motherhood was greater than the stigma attached to fertility treatments, which meant they had little choice but to seek medical advice, despite the risks associated with the treatment. The rise in infertile women seeking medical help has increased which will gradually reduce the stigma that is attached to such procedures (Forsythe, 2000). Conversely, Deka and Sarma (2010) argue that the increase in women utilising treatments will not reduce the stigma as many women view the process as a private matter and are unlikely to inform others of their decisions. However, they believe that as a result of the media, society is becoming more aware of different options for infertile women and the more people hear about the availability of fertility treatments, the more socially acceptable infertility treatments will become. Children born as a result of reproductive technologies is an ongoing debate, and is something which has recently been criticised by Italian fashion designers Domenico Dolce and Stefano Gabbana (2015), who referred to IVF babies as 'synthetic'. This criticism sparked outrage on social media causing Sir Elton John – father of two IVF-surrogacy babies – calling for a boycott of the fashion brand.

## 2.8 Limitations to the access of Fertility treatments

Despite infertile women having the choice to have fertility treatments in hope to get pregnant, there are limitations which may prevent them experiencing motherhood. Infertility treatments are a significant part of NHS services, yet whether or not a woman is eligible for IVF and how many cycles she is entitled to, is dependent on where she lives (HFEA, 2015). Mclean (2003) also argues that women and couples have to 'fit the criteria' and there are protocols to follow which are vital in the steps to becoming a parent when having such treatments on the NHS. The funding for procedures in areas across the UK are decided by Clinical Commissioning Groups (Jenkins et al, 2003). The National Institute for Health and Care Excellence (NICE) has criticised areas of the UK for not funding the full recommended number of IVF cycles (three full cycles of IVF for women under 40 who have failed to pregnant after 2 years of trying) and the deputy chief executive of NICE has argued that despite financial constraints, it is unacceptable that parts of England are choosing to ignore guidelines as this perpetuates a postcode lottery and creates inequalities in healthcare (Wise,

2014). Women who have a high body mass index (BMI) are often denied access to fertility treatments as obesity can be a risk to both the child and the mother (Jenkins et al, 2003). In addition, patients who already have children or who have partners with children from a previous relationship can be denied or 'put to the bottom of the waiting list', along with those who have previously had a failed IVF cycle (Jenkins et al, 2003). Women who are considered by their GP are likely to be placed on long waiting lists for treatments, with waiting times over a year long, thus further decreasing their chances of getting pregnant as the women gets older (HFEA, 2015).

Fertility clinics are obliged to check who will be legally responsible for the child and the suitability of those who are intending to bring up the child (Jenkins et al, 2003). However, HFEA (2001) argue that despite such checks, all women are considered for fertility treatments including women over the age of 45, as well as single or lesbian women.

Women who are declined by the NHS for their treatment do have the option to pay privately (Cole, 2010). It is estimated that nearly 45,000 cycles of IVF are performed in Britain each year and 20,000 of them are carried out in private fertility clinics (Cole, 2010). According to the Human Fertilisation and Embryology Authority (HFEA, 2015) which regulates private IVF clinics, the average cost per cycle is around £5,000, with more complex treatments easily costing as much as £12,000 (HFEA, 2015). However, many women are unable to afford the cost of the treatment and are forced to search for alternative methods to get pregnant (Ferraretti, 2010). Culley et al (2011) study explores the motivations and experiences of UK residents that travel abroad for fertility treatments and suggests there is an increasing amount of women who travel to areas where they can guarantee treatments for less cost than the UK. With a number of women unable to afford private treatments, it demonstrates that private healthcare in the UK is only accessible to women fortunate enough to have the resources to pay for their treatment. This suggests that women who seek fertility treatments are not only marginalised in society for not having the ability to have children but they are also discriminated by the NHS and private health care clinics who aim their products and services to wealthy women/couples (Pennings and Mertes, 2010).



## 2.9 Summary

Although statistics show that there has been an increase in women having their children older, the underlying belief that motherhood provides women with a sense of completeness and purpose in their lives remains a dominant discourse, as many women still yearn for motherhood. However, cultural approaches on motherhood downplay the intangible rewards that children give, such as emotional bonds and unconditional love and there is a presumption that all women who want children internalise pronatalist beliefs, rather than making a unique decision to have children themselves.

Society's expectations and women's desire to procreate have together been drivers for the birth of infertility treatments, along with the medicalisation of infertility. Infertility and the need for women to access medical treatments have been shaped by the social construction of womanhood being linked with motherhood. Liberal feminists suggest that women have benefitted from the development of infertility treatments as they have given them more life choices and have enabled many women to experience motherhood. However, infertility treatments may be a factor which has influenced the rise in 'older' mothers as it has made it possible for women to have babies older, despite the associated risks. It could be predicted that the increase in women delaying motherhood may alter society's view of the 'ideal' mother, as 'older' women are argued to have traits which are essential for motherhood.

## **Research Rationale**

The motivation to carry out research on this particular topic stemmed from that of personal interest, as well as a development of my undergraduate research. The topic of ‘older’ mothers who undergo fertility treatments is of heightened discussion within the media but the reporting is heavily focused on women who have children ‘older’, by natural conception. The rise in the use of fertility treatments as well as the increase in ‘older’ mothers has resulted in contemporary research being overwhelming pessimistic towards women who use assisted reproductive technologies. Infertility as a result of delayed motherhood is a heavily focused topic within contemporary literature, but ‘older’ motherhood as a result of infertility is often ignored. Many researchers fail to acknowledge that some women have no ‘choice’ over their reproductive timing and are using fertility treatments as a ‘last resort’ to have a biological child. Studies are predominantly quantitative and focus on the medical implications (Bay, 2013) and financial implications (Katz, 2011) of fertility treatments. They fail to critically analyse women’s actual experiences, perceptions and motivations; which are vital when trying to understand the social, cultural and biological issues, which may encourage or constraint women’s decisions to have assisted reproductive technology (Lampinen et al, 2009). Therefore existing literature potentially produces a distorted view of those who utilise fertility treatment when they are ‘older’.

It therefore felt necessary and worthy of study to undertake a qualitative phenomenological study which examined the ‘lived experience’ and perceptions of ‘older’ women who have been through, or are currently undergoing fertility treatments. This study intended to reduce the gap in research by promoting new insights into the topic area as well as to make a contribution to the body of existing literature.

## **Aims and Objectives**

Research Aim: To explore the views and experiences of fertility treatment among women over the age of thirty-five

### Objectives (Research Questions)

- 1) To explore why women over 35 consider fertility treatments
- 2) To investigate women's views on fertility treatment
- 3) To locate the findings in context of discourses of contemporary motherhood

## **Chapter Three – Methodology**

This chapter provides a rationale for the choice of methodology and methods which were adopted for this research project. A phenomenological approach underpinned by feminist values was applied and utilised as the theoretical framework for this research, and will therefore be explored in the first half of this chapter.

However, the main purpose of this section is to give an overview of the methods used to carry out the research and to give an explanation as to why these particular methods were favoured.

As feminist research is associated with strong ethics, this chapter will also pay particular attention to the importance of ethics within research and all ethical considerations will be guided by the British Sociological Association (2002). The pragmatic process of thematic analysis influenced by phenomenology, as a method of analysing qualitative data will also be explored later in this chapter. Other analysing techniques will be compared and contrasted to show the reasoning behind adopting the chosen method before drawing upon a conclusion.

### 3.1 Theoretical Frameworks

#### 3.1.1 Phenomenology

Phenomenology attempts to understand society by focusing on people's lived experiences, their behaviour and their interaction with the world, rather than their views and opinions of a given object or situation. Phenomenology was the chosen theoretical framework for this research as this study aimed to understand the essence of a phenomenon (fertility treatments) by examining the views of women who have experienced that phenomenon. - For Husserl, phenomenology involved a careful examination of human experience and he suggests that this should be done by stepping outside of our everyday experience in order to examine and give meaning to that experience (Smith et al, 2009). Like Husserl, this research assumed phenomenological research systematically reflects on everyday lived experience; it focused on the women and their unique experiences, rather than focusing on generalities. Phenomenology was chosen to underpin the methodology of this research as it allows moving beyond the text and interpreting the experience through insights derived from the researcher's own experiences (Dowling, 2011).

### 3.1.2 Feminism

Despite this research being underpinned by phenomenology, the chosen methods and research approach was guided by feminism and feminist values were adopted throughout. Harding (1993: p54) suggests that ‘the experience and lives of marginalised people, as they understand them’, provide appropriate research agendas for feminist researchers. Therefore a study such as this one which explores the lives and experiences of women who have been through fertility treatment is the most appropriate ‘agenda’ for a feminist research methodology. Feminist theory is particularly interested in analysing the status of women and men in society with the purpose of using that knowledge to better women’s lives (Ritchie, 2014). Women and their experiences are at the heart of feminist research and race, class and sexuality are seen as equal as gender (Hesse-Biber, 2014).

Feminist research is defined ‘as a focus on women, in research carried out by women, for other women’ (Stanley and Wise, 1990:p21). However, there are many strands to feminism which can alter the perceptions and methods within research; these strands include black, third world, postmodern, third-wave, liberal, radical, post-colonial, lesbian and cultural feminist (Lotz, 2003). Feminist research draws on elements of several available epistemological approaches and the use of postmodern feminism within this research helped guide the choice of methodology (Allen, 2011). All knowledge from a postmodern feminist perspective are viewed as socially and culturally constructed and research from this paradigm are highly thought of as they are seen to produce more complete and less distorted knowledge; which consequently makes the results much more reliable.

Although ‘feminist methodology’ does not exist, feminist often dismiss traditional methods of research which are standardised and rigid as they are deemed inappropriate when conducting research on women (Oakley, 1981). However, a feminist value within methodological approaches is that the research should be specifically concerned with how, or whether, knowledge produced about social life can be connected with the social realities of women (Landman, 2006). Therefore, feminist methodology is keen to understand the experiences of women, which produces subjective knowledge (Henn et al, 2008).

### 3.2 Ethical considerations

Prior to the research being carried out, permission from an ethics panel at the University of Huddersfield (see Appendix 1, 2 and 3) was required before the research could begin. All the

information about the study was approved; which included an information sheet (See appendix 4), a consent form (see appendix 5) and participant recruitment information.

Throughout the research, all ethical guidelines were followed in line with the British Sociological Association ethical guidelines (2002). Before the interviews took place, the women were required to give written consent (in the form of an electronic signature) to say that they had been provided with a detailed explanation as to what the research was about, who the researcher was, how the data will be used and what was required of them (Ritchie and Lewis, 2012). Giving the women a true representation of what research entailed avoided deception and signing the consent form meant that the participant had agreed to take part in the research and that they understood their participation was voluntary.

As the topic area for this research was a sensitive subject, it was apparent that participants would likely uncover painful experiences and share stories and feelings which they may have never disclosed before. Therefore it was imperative for the interviewees to be made aware that they would be protected from harm during the research. It was important that the questions asked during the interview were not too sensitive or personal to make the participant feel uncomfortable. It was crucial to be aware of signs of discomfort made by the participant in order to check their willingness to continue. Due to the sensitivity of the research, it felt necessary to de-brief the participant after the interview had finished. This small part of the interview was a chance to change the conversation to more everyday subjects so that the participant was not left with feelings and thoughts that were stirred up by the interview. Furthermore, de-briefing the individuals at the end of the interview created an opportunity to make sure that the participants did not feel uncomfortable during the interview. According to Curtis (2011) debriefing is used in research to talk about the interview and to ensure the participant was not distressed throughout the process. Despite the sensitive topic and being prepared with information and contact numbers for added support for the participants, nobody mentioned that they were uncomfortable at any stage during the interview.

Participants were made aware that any of the information they gave would remain anonymous and confidential; this was very important as it was imperative to protect the participant's identity. According to Ritchie and Lewis (2012), anonymity means that only the research team know the identity of those taking part, whereas confidentiality means that any identifiable information about individuals collected during the process of research will not be

disclosed and details or comments in reports or presentations such be avoided, as this may lead to identifying the participant (Wiles, 2013). Ritchie and Lewis (2012) argue that ensuring anonymity and confidentiality can have implications when storing data. They argue that tapes and transcripts should not be labelled in ways which could affect the anonymity of the participant. Therefore the interview recordings and transcripts in this research were labelled with a pseudonym to protect the individual's identity, and the recordings were stored on a password protected computer where only the interviewer could access.

### 3.3 Research Methods

#### 3.3.1 Qualitative approach

Despite considering quantitative methodology for this research, it became apparent that the nature of the approach was not suitable when researching women's perceptions of a certain phenomenon. It was therefore appropriate to adopt a qualitative approach which is 'interested in analysing the subjective meaning or the social production of issues, events or practices by collecting non-standardised data and analysing texts and images rather than numbers and statistics' (Flick, 2009:p472). Utilising qualitative research which is based in an interpretative paradigm was exploratory in nature and allowed the researcher to gain information about an area where little is known (Liamputtong and Ezzy, 2005). Carrying out qualitative research allowed an exploration of the reasons and motivations for perceptions, beliefs and behaviours of the women and could produce a better understanding of the lived experience of using fertility treatments (Donley, 2012).

#### 3.3.2 Sample

A sample is a segment of the population that is selected for investigation (Bryman, 2012). Phenomenological studies are conducted using small samples as they look for a fine-grained account of individual experience (Smith et al, 2009) The sample in this research was ten women over thirty-five (the eldest being aged forty-five), who had been or were going through fertility treatments. Despite an open inclusion/ exclusion criteria, all the women who were interviewed for this research were White British, from middle class backgrounds and in heterosexual relationships. This general observation showed that although this research was specific in that it required women from the UK who are over a certain age, all the women who came forward had similar demographics. Furthermore, it is interesting to note that this research used the term 'fertility treatments' very loosely when recruiting the sample.

However, all the women who opted to participate had specifically been through IVF treatment, and whilst we cannot generalise from such a small sample, this suggests the HFEA (2013) is right in saying the most common form of assisted reproductive technologies is IVF. The women in the sample were having IVF as a result of their own or their partners' infertility and although the majority of the women were trying for their first child, others had previous children either through natural conception or fertility treatments.

The sample used could have been classified as what Abrams (2010) argues to be a 'hard to reach' sample. Fertility clinics cannot disclose patients' information due to confidentiality, and women may not want to disclose any information due to the sensitivity of the subject. Furthermore, the sample was very specific as there was a required age that participants had to be which made it increasingly difficult to gain participants. Qualitative and quantitative research methodologies have different sampling goals and strategies, and due to qualitative samples being typically small, they are generally not seen to be representative (Abrams, 2010). However, within the qualitative research paradigm, sampling is varied according to paradigmatic and disciplinary traditions, and according to Hesse-Biber (2014), both phenomenologists and feminists tend to favour small samples where individuals share a common experience as they are known to produce a solid understanding of the participant's involved. Like the majority of other qualitative research, the goal of this research was to look at the 'meanings' women give to their social situation and not necessarily make generalisations.

### 3.3.3 Sampling technique

The sampling technique used to gather the women was self-selected. Self-selected sampling is when a participant volunteers to take part in the research when being asked to or in response to an advert (Neuman, 2014). In this research, no direct contact was made with the participants until they volunteered themselves to take part. Potential participants were made aware of the research through a social media website (Twitter). The research was promoted on a twitter account which was purposely set up for this research (see appendix 6). Organisations which had twitter accounts were also asked to help advertise the research. An email address was displayed on the twitter account so that potential participants could make contact with regard to taking part. Marshall and Rossman (1999) argue that this type of sampling is 'naturalistic' as it takes place in ordinary settings where people 'do' their lives. For instance, the women who came forward for the research used twitter as part of their daily



routine, and some of the women ‘followed’ the organisations which promoted this research. The advantage of using a social media website to gather a self-selected sample is that it is relatively quick and easy to do. However, self-selected samples are criticised for not being representative to the target population as the type of people who opt themselves to take part in research may have similar characteristics to each other. Despite the process of recruiting participants taking a little longer than expected, the overall response rate from participants was better than anticipated which suggests that self-selected samples through social networking websites are a contemporary method which works well when attempting to find ‘hard to reach’ samples. Although there was a time restriction on this research, it is anticipated that more participants would not have developed new knowledge about the topic; rather it would have led to data saturation. Ten participants was an adequate sample for this research as it was interested in individual experiences rather than developing generalisations about shared realities

#### 3.3.4 Data collection method

Successful phenomenological research requires a method of data collection that facilitates a first-hand description of the phenomenon under examination and it is significant that the participant will mainly determine the course of the dialogue (Cope, 2011). Therefore semi-structured telephone interviews were chosen to be carried out. As this research adopted a feminist stance, semi-structured telephone interviews were an appropriate method to utilise as according to Bryman (2012), they have become an extremely prominent method of data collection within a feminist research framework (David and Sutton, 2004). Such interviews use a number of pre-determined questions to give the interview some degree of structure and standardisation whilst also giving the participant freedom to digress from pre-set questions and to speak freely and openly about their experiences (Berg, 2009). The interview schedule utilised (see Appendix 7) was developed specifically to meet the aims of this research and the questions were guided by topics within existing literature. The use of standardised questions for at least some of the questions increased the data reliability.

Due to the nature of this research, semi-structured telephone interviews were the most appropriate method to gather a full understanding of each of the women’s subjective perceptions and experiences of fertility treatments. As the method which is upheld by feminist values, it was of particularly importance that the interviews also developed an insight into the meanings that the women attached to their experiences. A benefit of using

feminist interviewing within this research is that it attempts to be more reflexive, and aims to take a non-hierarchical approach which avoids objectifying the participant (King and Horrocks, 2010). In addition, semi-structured interviews were utilised as they allowed responses to be explored and allowed the researcher to be responsive to relevant issues raised spontaneously by the interviewee. However, Ritchie et al (2014) argues that the opportunity to ask questions freely, based on what the interviewee has said can be problematic as the participants responses could be affected by interviewer bias. On the other hand, an advantage of using semi-structured interviews was that participants were less likely to answer questions in a social desirable manor which is often a problem when conducting questionnaires (Hesse-Biber, 2014). Furthermore, replication is possible with semi-structured interviews, despite them not been as standardised and replicable as structured interviews.

When researching a sensitive topic like the one in this research, it was important to develop rapport whilst still maintaining boundaries with the participant (Dickson-Swift et al, 2007). The rapport building process was initiated from the first encounter with each participant, so that a rapport was built to allow each woman to feel as comfortable as possible to tell her story during the interview (King and Horrocks, 2010). Developing rapport can be seen as one of the most important aspects in successful qualitative research and unlike questionnaires or observations, it is essential for methods where the participant is talking openly about personal experiences (David and Sutton, 2011).

### 3.4 Pilot study

A pilot study was performed before carrying out the interviews to highlight any minor flaws in the method or any problems in the research questions. The benefit of conducting a pilot study was that it provided an opportunity to make adjustments and revisions to the main study (Kim, 2011). Receiving feedback from a participant in the pilot study helped modify interview questions for the main research.

Carrying out a pilot study was one way of been reassured that participants could easily be accessed and confirmed that there would be little or no issues when gathering the number of participants for the main study. A pilot study was also useful in this research as it ensured that the interview could be completed in the time specified. Furthermore, the audio recorder was tested previously to the interviews been carried out; to ensure that it could record for the length of an interview and to confirm that the recordings were of good quality to later transcribe. Pilot studies are a crucial element of a good research design and although

conducting a pilot study does not guarantee success in the main study, it does increase the likeliness of success (Stand, 2002).

### 3.5 Analytic method

Due to the nature of this research, thematic analysis which was underpinned by phenomenology was chosen to analyse the data. When unpinned by phenomenology, thematic analysis is comprehensive and therefore time consuming, as it involves identifying themes in the data to seek relationships and overarching patterns, whilst paying particular attention to understanding peoples everyday experience of reality (Burnard et al, 2008). The procedure which was followed to carry out the analysis was guided by Braun and Clarke's (2006) theory and their analytic terminology was adopted throughout the process. Braun and Clarke (2006) are amongst the few theorists to acknowledge thematic analysis as a method in its own right and they emphasise the benefits of its theoretical freedom and ability to be flexible. They also argued that when carried out in a rigorous way, thematic analysis can potentially provide rich and complex data.

This research aimed to analyse the data at a latent level which Braun and Clarke (2006) argues is the process of not just describing the data, but attempting to identify the underlying assumptions and ideologies which shape the content of the data. The analytic process began by transcribing all interviews verbatim onto a word document and they were analysed using Braun and Clarke's (2006) six phase thematic analysis (see appendix 7). The analysis was carried out by hand and the first process was to read and re-read each transcript thoroughly in order to become familiar with the respondents' views and experiences. Phase two involved the production of initial codes which were both 'data-driven' and 'theory-driven'. Phrases and words which sum up what was being said in the text were annotated in the left hand margin. Bearing in mind that the key product of phenomenology is the lived experiences of the participants, it was very important to prevent the data from being prematurely categorised. The same process was carried out on each transcript and a list was created on a separate document which included all emergent codes. These codes were collected and reduced by eliminating duplications within phase 3, and emergent themes were noted in the right hand margin. Often there was an overlap in the themes, which was anticipated, considering the nature of human phenomena. In addition, the relationship between codes and levels of themes (main overarching theme and sub-themes within them) were beginning to emerge during this phase. During phase four, themes were refined and where some of the

themes were split or brought together, others were discarded. Phase five was allocated to identifying the 'essence' of each theme and to give each theme a 'punchy' informative name. Within this phase, a 'thematic map' was produced to illustrate the final themes and to represent the relationship between each of them. Finally, phase six was dedicated to the write-up of the analysis where a concise interesting account of the data was presented and contextualised in relation to existing literature.

The process of analysing the data did involve interpreting the findings which some may argue was subjective (Boeije, 2012). Quantitative researchers would criticise qualitative analysis by arguing that the data cannot represent the social world as different researchers may interpret the data differently (Boeije, 2012). However, from a phenomenological perspective, this research used an inductive approach to identifying the themes within the data set. This means the actual data itself was used to derive the structure of analysis (Burnard et al, 2008). Carrying out an inductive analysis within this research meant that there was a long process of coding the data without trying to utilise pre-existing coding frames. In addition, this research ensured that the process of analysis was systematic and rigorous by analysing all the data collected, including relevant anomalies. Furthermore, as this phenomenological research was underpinned by postmodern feminism, it was of particular importance to ensure interpretations and meanings stemmed from the data, rather than from the researcher's preconceptions. However, it has been acknowledged that it is impossible to completely remove researchers' perspectives completely in phenomenology (Lewis and Staehler, 2010).

Despite making comparisons between different methods of analysis prior to the research been carried out, thematic analysis which is underpinned by phenomenology was the chosen method which best suited the research questions; as it is a method which provides an insight into the meaning of lived experiences. Despite being time consuming, the advantages of using phenomenology with thematic analysis is that it provided rich and detailed descriptions of human experiences which developed better understandings of meanings which are attached by society. Discourse analysis is similar to thematic analysis, but the method fails to develop research data that is applicable to real world settings that exist outside of an individual's experience (Wodak and Meyer, 2009). However, in contrast to methods like discourse analysis and content analysis, thematic analysis does not allow the researcher to analyse the use of language and emotions throughout the interviews (Parker, 2005).

On the other hand, thematic analysis allowed this research to gather what is seen as ‘natural’ data rather than artificial, which increased the validity of the study; despite phenomenology having lower levels of validity and reliability compared to positivist methodologies.

### 3.6 Procedure

Once the respondents had shown interest in the research, they were sent an information sheet via email (see appendix 9) where a detailed description of the research and their involvement was given. If they were happy to continue, they were then sent a consent form prior to the interview, all by email (see appendix 10) - and they replied with their written (electronic version) consent. It is noteworthy that all of the women who came forward were happy to continue their participation to the end of research process.

Ten phenomenological semi-structured interviews were carried out with women over thirty-five. The interviews took place over the telephone because not only was the response rate higher in comparison to face-to-face interviews, but the cost and time was considerably less than travelling to meet the participant (Dane, 2011). The key points which were mentioned in the information sheet were stated again at the beginning of the interview to ensure the participant still wanted to take part. Each interview was audio-recorded so that the interview could be transcribed onto paper at a later date. Advantages of using telephone interviews for this research was that participants from a wide geographical location were able to participate and interviews were safer than face-to-face interviews for both the interviewer and the participant. The interviews lasted between forty to ninety minutes, with most the majority lasting approximately one hour long. The participants were asked open ended questions which allowed for greater depth and personal detail in their responses (King and Horrocks, 2010). Although open ended questions were more challenging to analyse, there was less chance of the women misinterpreting a question or being forced to give a simplistic response to such a complex issue; which is a common problem with questionnaires, where closed questions are used (Neuman, 2014). The interview schedule was indicative and the questions were asked to the interviewees at different times in the interview depending on the flow and topic of the conversation.

The six phase analytic process (Braun and Clarke, 2006) of phenomenological thematic analysis was then carried out.

### 3.7 Summary

This chapter has introduced and discussed the choice of phenomenology as a suitable research methodology to capture and understand the in-depth ‘lived experiences’ of the ten women in this research. Both the data collection techniques and the analytic method which was adopted for this research have been explained in great detail. This research aims to promote thematic analysis as a process which is a flexible and useful method; as in the past it was often poorly acknowledged and rarely appreciated (Braun and Clarke, 2006)

Finally, this research was carried out with no major problems or disruptions and all of the women who came forward were happy to continue their participation throughout the study. It is of particular significance to mention how all of the women openly told their very personal experiences and they were all comfortable in sharing their perceptions of fertility treatments.

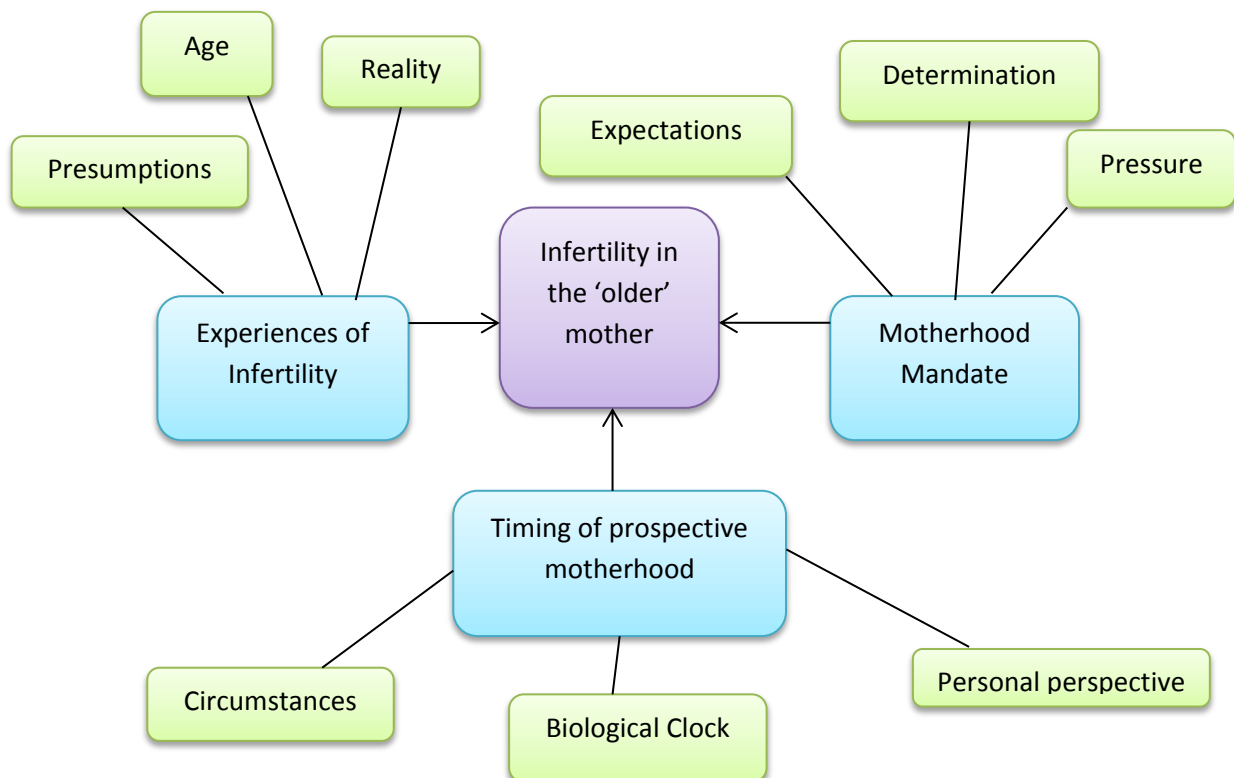
The following chapter will show the analysed findings of the interviews that the ten research participants engaged in.

## Chapter Four – Findings

### 4.1 Overview

The following interpretation of the interview transcripts demonstrates ‘older’ women’s perceptions and experiences of fertility treatments. As summarised in Chapter three, applying a phenomenological approach to thematic analysis required a multidimensional process of constructing, de-constructing and clustering emergent themes. This process resulted in the emergent of three case-specific themes which were ‘Experiences of Infertility’, ‘Timing of prospective motherhood’ and ‘Motherhood Mandate’. The overarching context was ‘Infertility in the ‘older’ mother’ which underpinned the three main themes throughout. In order to conceptualise this, figure 1.0 presents a diagrammatic representation of this overarching context.

Figure 1.0: Diagram of Themes



Although the themes are not presented in order of priority, theme one ‘Experiences of Infertility’ is particularly significant in that it explores the reality of being infertile and seeks to understand a woman’s unique experience of having fertility treatments. Theme two, ‘Timing of prospective motherhood’ is fundamental in displaying the level of importance the respondents place on the ideal age to become a mother and the right time in their lives to start trying for a family. Finally, ‘Motherhood Mandate’ is a theme which is particularly important as it suggests the reasons why some women desire to have children and their motivations to have fertility treatments. It views motherhood as a natural occurrence and as a societal expectation which is essential to fulfil the ‘role’ as a woman. It is worth acknowledging that the themes and subthemes may occasionally overlap, as each form of experience may interlink.

It is necessary to mention that the themes and subthemes that reoccurred throughout the data are inextricably linked, as they consist of factors which all contribute to shaping the views and experiences of the women in this research. Thus every effort has been made to ensure that an artificial distinctiveness is not imposed on the data set. The analysis includes quotes from the interview transcripts to show consistency between the research data and researcher interpretation.

All names that are used throughout this chapter are pseudonyms, in order to conceal the participant’s real identity. Table 2.0 gives a brief overview of the women’s age and infertility background at the time of the interview.

Table 2.0: Overview of participants

<b>Pseudonym</b>	<b>Age</b>	<b>Fertility Overview</b>
Sally	37	Infertile as a result of two ectopic pregnancies and pregnant with first baby after six cycles of IVF – including 5 fresh cycles and 1 frozen cycle
Nina	37	Infertile due to previous health complications, no children and about to start her 2 <sup>nd</sup> fresh cycle of IVF.
Kate	35	Husbands infertility and pregnant with second child through IVF.
Jade	36	Had a son aged 4 through natural conception. Having fertility treatment as a result of husbands infertility caused by cancer/chemotherapy and is currently twenty weeks pregnant with twins through IVF.
Viv	38	Infertile as a result of endometriosis. Had first child after successful first cycle of IVF. Miscarried second baby and third pregnancy was ectopic - now 38 weeks pregnant following IVF.



Fiona	39	Two miscarriages with first two natural pregnancies, miscarried twins in fourth pregnancy, new partner had low sperm count so utilised IVF to help conceive. Miscarried baby after first IVF cycle, second IVF fresh cycle was unsuccessful and she is about to start third fresh cycle.
Lyndsay	35	Had two children age seven and three weeks old – ectopic pregnancy prior to having first child and then had a baby naturally. Experienced three miscarriages before having first cycle of IVF to help conceive with her second child.
Isla	35	Husband's infertility and previous medical condition caused her to have both fallopian tubes removed. Pregnant with her son after four cycles of IVF.
Amy	45	Successful IVF pregnancy with first child and now pregnant with second child after 8 <sup>th</sup> round of IVF. Used donor eggs for last 5 cycles. Infertile due to premature ovarian failure and early menopause. Both successful cycles were carried out abroad in Spain due to the long waiting lists in the UK.
Gill	38	Currently been trying for 8 years to have her first child. Unexplained infertility and had three failed IVF cycles.

#### **4.2 Infertility in the 'older' mother:**

The central context to which this study was set is 'infertility in the older mother'. The definition of an 'older mother' that was adopted within this research was that an older mother is somebody who plans to have a child at or over the age of thirty-five (Carolan et al, 2013). It is noteworthy that despite the women in this research falling in the category of an 'older mother', only a very small proportion were identifying themselves as 'older'. Within existing literature, cultural dominant understandings constitute 'older' mothers as 'selfish' and 'choosing' to delay motherhood and 'rely' on fertility treatments. However, none of the women identified with this representation and they often worked to resist it by negotiating that 'older' mothers are 'good' mothers. In addition, despite there been a presumption that infertility in 'older' mothers is age-related, the data revealed that those women who were infertile themselves (rather than their partners), were infertile as result of previous ongoing infertility and medical conditions and these unplanned circumstances often delayed their life plans and placed them in the 'older category'.

#### **4.3 Experiences of infertility**

A theme clearly shown throughout all respondents' interviews was related to their 'Experience of Infertility'. The sub-themes which related to this theme were 'Reality', 'Age' and 'Presumptions' and these will be expressed in more detail later. Despite the subjective nature of examining women's experiences, there was a general consensus within the data

regarding their experience of infertility and fertility treatments. Despite not being directly asked whether or not the women thought infertility was a taboo subject, the majority of the women expressed that there is stigma attached to such phenomenon and there are presumptions in society regarding infertility and the use of assisted reproductive technologies.

#### 4.3.1 Reality

There is an emphasis on women ‘relying’ on fertility treatments within existing literature and they suggest that women utilise the treatments as a ‘back up’ plan if they are unable to conceive later in their life. However, the data revealed this finding to be exaggerated as only one woman in the research thought the advance in technology has made women ‘rely’ on fertility treatments to get pregnant. The remaining nine interviewees showed signs of shock as they could not understand a woman’s motive for risking her own fertility in order to have children older through fertility treatments. These women explained how fertility treatments are often misconceived from outsiders as something which resembles a fairy-tale; something which is easily accessible, a fast process and something that is likely to give you a child.

None of the women purposely postponed having children or thought infertility treatments would be something that they would experience. Sally, who was age thirty-seven and pregnant with her first baby after six cycles of IVF, was infertile as a result of two ectopic pregnancies. She expressed how she thought she would always be able to have a child naturally...

*‘...I didn’t delay having children because of fertility treatments and I didn’t think that I would ever need fertility treatments. I always thought that I would always be able to have a child naturally if I tried in my later twenties/early thirties.’*

Similarly to Sally, Nina also did not expect to use fertility treatments to aid her conception, but Nina struggled coming to terms with this reality. Nina was thirty-seven and infertile due to previous health complications which resulted in having her colon removed. She expressed how her medical condition worsened very quickly, causing her to have an emergency operation which left her unable to conceive naturally.

*‘...I couldn’t believe they were actually sending me for IVF...I was just so so shocked. I was just thinking that surely my body can do this itself and I did everything I could. I spent and still am spending so much money on expensive vitamins, herbal medicines and acupuncture. I tried to do*

*everything I could before I accepted that I needed to go to the bank to get a loan to pay privately. I didn't want IVF... I never once thought 'IVF, yes IVF is the answer'. - Nina*

Like Nina, some of the respondents believed that a woman's role in society is to reproduce and when they were told they couldn't perform this role, they found it hard to accept that they would need fertility treatments. This could be linked to 'expectations' which is a sub-theme mentioned later in this chapter. A gender expectation of women is to bear children and when a woman cannot perform this norm, she struggles to accept that she has 'failed' as a woman. This is in line with Martin (2010), who believed that women encounter psychological issues when the procedure does not work as it reinforcing the ideology that she has failed to become a mother.

Furthermore, the data revealed that women are also faced with the reality that fertility treatments are in no way a replacement for a woman's natural ability to conceive, and they may not be successful. Brandes et al (2011) argue that there is more chance of procedures not working than there is working. Some of the respondents expressed how they felt when the procedure was not successful for them. Gill who was age thirty-eight and had unexplained infertility, had been trying for eight years to have a baby and she was frustrated and upset when she experienced three failed IVF cycles:

*'...to be honest at the time I was a little bit too distraught to do anything. You know, it takes its toll on you to think that you've got to have another go and another go. I think it's quite a harsh thing to like come to terms with because I really believed it was going to work. When it doesn't work, it makes it more real' – Gill*

Kate was having fertility treatments due to her husband's infertility and she experienced failed IVF cycles like Gill:

*'We started to think about how many times we would need to go through IVF if every time it didn't work. We had to think about an age or a point in our lives where we would have to give up if we hadn't got a baby... they say that you have like a 30/33% chance of working each time so we thought well we would try it 3 times altogether so that we know we have had a chance. So yeah it was a really horrible time...' - Kate*

The data revealed that despite the women being aware of the success rates, it still did not prepare them for the reality of failed cycles. The women expressed signs of shock and disbelief and explained the difficulties of having to think about a time in their life when they will have to accept childlessness as a definite. The respondent's feelings towards infertility and fertility treatments were prominent throughout the interviews and although there was a consensus regarding the reality of failed treatments, one of the women's views captured the

real heartache of having fertility treatment. Jade was age thirty-six and was twenty weeks pregnant after having IVF as a result of her husband's infertility. She stressed:

*'It is a horrible process; this has been as stressful as my husband having cancer I would say...it has been an awful process! People should be aware of the risks of infertility in older women and how stressful infertility treatments are.'* - Jade

The most poignant part of Jade's interview was when she expressed how her fertility treatment had been as stressful as her husband having cancer. This comment oozes so much pain and heartache and the fact she made a similarity between her infertility journey and a deadly disease shows the amount of suffering infertility causes. When exploring women's experiences like Jade's, it could be argued that existing literature fails to highlight the true extent of anxiety which fertility treatments can cause. The data revealed that a number of failed cycles can cause women to experience uncertainty throughout a successful pregnancy. Viv was thirty-eight weeks pregnant with her second child through IVF, but she miscarried a baby and experienced an ectopic pregnancy prior to her current pregnancy:

*'While it is obvious that I am pregnant as he is wriggling around all over the place in there...there is no 'congratulations' as there is no baby until he is born. Even though they have done scans there are some problems that don't show up until they are born. Some people are like well of course you're pregnant and of course you will end up with a baby...which is not what you feel. I mean I was in tears in all of my antenatal appointments and scans.'* - Viv

Despite many of the women being concerned throughout their successful pregnancies, Viv's response in-particularly represented the 'emotional roller-coaster' which she encountered during her pregnancy journey. At thirty-eight weeks pregnant Viv viewed her pregnancy as a 'matter of fact' and tried to detach herself from the overwhelming emotions that pregnancy brings. This shows the reality of infertility and the effects infertility treatments have on those suffering with it; something which others often disregard.

#### 4.3.2 Age

As women get 'older', her chance of getting pregnant declines, whilst the chance of miscarriages and other medical problems increase (Maheshwari et al, 2008). In the past, women who were infertile had to accept that they no longer had the ability to have children. However, women now have more options to fulfil the role of motherhood due to the medicalisation of infertility and the development of treatments. Women explained how fertility treatments enabled them to have children 'older' and Viv in particular viewed such treatments very highly:

*'I am an older mother at 38 and I wouldn't have been able to have this child without IVF. If I think back to...maybe a generation ago...I wouldn't have been able to have children if I was 38 and struggling to have a child naturally. So yes obviously IVF has enabled me to have 2 children. I didn't want to be an older mother but at least I am a mother.'* - Viv

The women were aware that fertility treatments allowed them to have a child later in life, however the majority of women expressed their concerns with regard to the decline in success rates as a woman gets older. Fiona, aged thirty-nine, was the second oldest participant and was about to start her third cycle of IVF after experiencing a number of miscarriages and a failed IVF cycle. She explained how she felt having treatments 'older':

*'Unfortunately I do feel like it's an uphill battle as I am getting older now and at 39 you look at the statistics and it just screams back at you...you know, basically I have very little odds of it working. But, I do see it working...I am on twitter and infertility forums and there are people in similar situations that are getting pregnant...but fertility treatments have lower success rate as you get older just like natural pregnancies. It also takes a lot of time to even get referred, especially with the NHS so it is impacting on the chances of success.'* - Fiona

The ideology that long NHS waiting lists impact on a woman's chance of success is parallel with the Human Fertilisation and Embryology Authority (2015) who suggest that waiting times of over a year can jeopardise the chances of success in 'older' women. This was a particular concern for Amy who was the oldest participant in this study (aged forty-five), who chose to have both of her IVF treatments abroad which lead to successful pregnancies. She expressed:

*'This was my 8<sup>th</sup> round of IVF but I used a donor for the last 5 cycles. We did our first round when I was 38 and did 3 more quite close together but it was not going to work. So we went to Spain...we decided on Spain because there were no waiting lists at the time. On the NHS there was a 2 and half year wait for donor eggs and I was already 39 so I didn't want to hang about... The cost was not the reason for going [to Spain for treatment] because there is no difference in price. The only reason we went to Spain was because of the waiting time here in the UK.'* - Amy

Culley et al (2011) explored the motivations for UK residents travelling abroad for their treatment and found that women travel to areas where they can guarantee treatments for less cost than the UK. However, this research contradicts Culley et al (2011), as Amy explained that the cost of the treatment was the same as the UK and her motivation for having treatment abroad was to avoid the NHS waiting lists.

According to HFEA (2014), the NHS funding is decided by Clinical commissioning groups (CCG) across the UK and they are likely to utilise their funding by treating younger patients who are more likely to respond to treatment (McTernan, 2014). Similarly, participants

explained this in their interviews. Lyndsay, who was thirty-five and therefore one of the youngest participants, had IVF to help conceive with her second child and she explained:

*'Some hospitals only give treatment to women who are 35 and under but a lot of research shows that your fertility declines as you get older...so it doesn't make sense. There's women who have age-related infertility yet can't have treatment on the NHS because they are too old. These clinics are too worried about their success rates and therefore don't want to treat older women. It's just not fair....I suppose there should probably be an age limit of 50. I guess the NHS needs to think about the value for money...so the statistics of women age 40 and particularly after 42 show that there is less chance so I would say that I can see why they cut it off there.'* – Lyndsay

Furthermore, Gill argued...*'you might not meet somebody until your 39 and then you get to 40 and you think about a child. You can have a child but they won't give you any treatment because your 40...I know it's less chance of working when you get to 35, but I think everybody should be entitled to have a go, as long as they're fit and healthy.'* - Gill

The data revealed that in some cases, 'older' women can be refused access to fertility treatments due to their age. National institute for health and care excellence (NICE, 2012) explains that fertility treatments are only available in certain situations - because of NHS lack of funding and resources. There is a huge emphasis on 'older' women having the choice to have fertility treatments (Woolett and Boyle, 2000), but it has become apparent that external factors such as 'lack of funding and resources' affect women who are older and may prevent them from having treatments; something which existing literature has failed to mention. It is under documented that some 'older' women may 'fall short' when enquiring about treatments, especially those experiencing age-related infertility. It was apparent within this theme that 'older' women are likely to feel disadvantaged when they access treatments and the likeliness for success decreases with age.

#### 4.3.3 Presumptions

Lee and Gramotney (2006) argue that there is a presumption within society that all childlessness is voluntary. This theory goes against pronatalist ideology and assumes women consciously decide not to have children. Views of this theme reoccurred during the interviews and Nina who has no children as a result of previous medical complications expressed:

*'I think people might assume that women of my age...late thirties... haven't even considered it and not tried to have a baby. When actually there are a lot of women out there who are past child bearing age without a child and if they actually stopped and asked them...although they may probably tell everybody that they didn't want children, they may have tried and not been able to or may not have met anybody in time to have children with. I think that is very sad and sometimes I think society assumes that these women didn't want children, when really it's*

*down to circumstance. I think that is a bit annoying actually...it isn't something I have just suddenly thought about in my late 30's. It is something I have always wanted since being a teenager and onwards and never been able to.' - Nina*

Nina's response is in line with Lee and Gramotney (2006) theory as they both suggests that society presumes that childless women and couples are childless by choice and they ignore circumstances which may have resulted in them being without children. It can be suggested that existing literature and society often ignore infertility as a reason why women are childless and they 'presume' women are childless by choice.

Another 'presumption' which emerged from the data was that society assumes that a couples' infertility is female related. This corresponds with Chambers (2012) theory which suggests that women bear the blame for reproductive failing within a heterosexual relationship. Male infertility accounts for at least half of infertility cases globally (NHS, 2014) but male infertility is unrepresented in literature. Fiona who was thirty-nine explained what she found the most 'interesting' during her treatment:

*'...And do you know what I have found out the most after having fertility treatments? People always presume that it is the woman that has fertility problems rather than the male partner.' - Fiona*

Similarly, Kate stated that... *'People think women are having fertility treatments because they are the ones that are infertile...but that's not the case for a lot of people.'*

The presumption in society that infertility is a 'women's problem' may originate from the discourses of motherhood which suggest that a woman's role is to reproduce (Ulrich and Weatherall, 2000). Furthermore, such presumptions may also stem from the ideology that women undergo the physical aspects of fertility treatment regardless of whether it is their own or partner's infertility. There were a number of women who were undergoing treatment as a consequence of their partner's infertility and this is something which is often ignored within published academia.

The presumption which had the biggest impact on the women in this research was the assumption that an 'older' women's infertility is age-related and a result of them 'leaving it too late'. The women in this research found themselves at the brunt of social stigma and presumptions made by society because they were all over the age of thirty-five; where a woman's fertility is thought to dramatically decline (Lancet, 2014). However, there were no women in this study who had infertility as a result of delaying motherhood. Although presumptions are based on probability, this finding shows how such presumptions can be

misleading and inaccurate. When society presumes that older women are infertile because of their age, they are assuming that the woman has not had any signs of infertility previously. However, the majority of women in this research who were infertile themselves explained how they had previous medical conditions which caused infertility. Lyndsay also mentioned how a large network of women on social media websites also had infertility as a consequence of underlying medical conditions:

*'I think the older you are, there is a presumption that infertility is to do with your age. Certainly within the media...I think there is a focus on age-related infertility which is a very relevant factor but it is not the only factor. In fact, a lot of people I know...well I say know...but they are all from twitter - most of the women have underlying medical conditions rather than being age related.'* - Lyndsay

This suggests that the older the woman, the more likely society is going to presume she is infertile as a result of a 'selfish' choice (Budds, Locke and Burr, 2013). Furthermore, Infertility can be 'silent' and a woman (or man) can suffer with infertility without being aware they have it. A person usually finds out they have infertility when they are actively trying for a baby. However, existing literature ignores the ideology that these women may have been infertile for many years previously but have only just been made aware of it (Homan et al, 2007). Jade discussed her views on societal presumptions and explained:

*'On 'this morning'...they had a fertility week where they spoke about everything infertility and they focused on age. I find a lot of support on twitter for IVF and I certainly found a lot of backlash on twitter at 'this morning' for focusing on age and fertility treatments. I know somebody who is 23 and has endometriosis so women who are 35 haven't always just got infertility problems...they may have had it 10 years but have been trying for all that time to have a baby...but people don't think that, they think it is because they have left it too late and that it is their fault that they are struggling to have a baby... I think people do judge and I think people would say that it was because they put their career first but if they had a job straight after school and realised in the twenties that they couldn't have a child...people wouldn't presume it was because of their age...it is only when women are in their 30's that people begin to think their infertility is a consequence of them being selfish and living their life basically.'* - Jade

There is a presumption that infertility is a result of increased age and although there is a correlation between the two factors, it is not always the reason why a woman has infertility. Although Letherby (1999) argues that society often ignores the idea that 'older' women may have had previous ongoing fertility treatments, little research has been carried out in this area and therefore the presumption is ongoing.



#### **4.4 Timing of prospective motherhood**

The timing of prospective motherhood was a prominent theme throughout the respondent's interviews and the decision to have children at the 'right time' was primarily effected by their own or partners infertility. However, the women also mentioned other phenomena's which affected the timing of motherhood and these were predominantly discussed within the sub-themes 'social circumstances', 'personal perspective' and the 'biological clock'. As the sample in this research was 'older mothers', the women heavily focused on the trend to have children later in life, despite expressing their views on having children younger.

##### **4.4.1 Social Circumstances**

The women in this research were having fertility treatments as a consequence of existing underlying medical conditions, husbands infertility or previously experienced ectopic pregnancies which resulted in their fallopian tubes been removed. Despite this, nine of the women believed that social circumstances contribute to delayed motherhood. For example:

*'I think it [timing of pregnancy] depends on your circumstances and how stable your relationship is and how financially secure you are. I think for some women it is important to build a career before having a baby and I just think that it is the natural thing to do now...Women start to think about a family older than they did when our parents did because women do want to have a good job and be settled in a home but I think that is because the norm has changed - so you can't blame the women as that is just how life happens...I think women are under a lot of pressure when it comes to juggling a family and a career. Overall I do think it [timing of pregnancy] is down to circumstances though.'* – Kate

*'We're concentrating on careers and buying houses and doing all the other things which are hard to establish and because of that, things are happening later than they would 30 years ago... I don't think that you should have children in the wrong context in order to have them young. So if you were financially unstable, in the wrong relationship or missing out on education then that would be wrong in order to have children.'* - Sally

The data revealed that the majority of participants thought finances, being settled in a home, careers and being in a stable relationship were all circumstances which get in the way of motherhood. Sally noted that women are concentrating on the things which are 'hard to establish'. This could indicate that although women are prioritising other things over having children, they are realists in that they understand the financial burden of children and therefore aspire to have a well-established lifestyle prior to motherhood. Sally thought that having children in the wrong context just to have children young is not ideal. However, those who favour younger mothers for being within the 'prime reproductive years' often expect

women to have their life already established and ignore that they may not be financially ready for parenthood (Selvaratnam, 2014).

Due to circumstances, the women expressed how they believed the priority to have a family was further down the line.

*‘I do think over the last decade there has been more pressure for girls to have careers...I don’t think it was like that before as the guy was the breadwinner and the women didn’t work as much. So I do think that the pressure of having a career will obviously effect the timing of pregnancy, then they need to get a house...which are not cheap and then they will have to work full-time to ensure they can pay for the house, so the priority to have a family is a little bit further down the line now.’ - Fiona*

In addition, Lyndsay’s beliefs coincide with Fiona’s thoughts as she revealed *‘I just think our culture is different now. I think children are now encouraged to extend education and go to university and so children come late down the line. Whereas, when my mum was younger, having children in their twenties was the norm. It is different now...not that family is put second, I just think that women in particularly and their careers have changed in the last 40 years and so everything else has changed with that.’ - Lyndsay*

Many of the women argued that ‘norms’ have changed from what they were 30 years ago. Women were less involved within education and the work industry and they were more likely to stay at home and look after children. Women have more commitments now and circumstances have changed meaning women think about having children a lot later than they did before. There is a lot of stigma attached to women who go to work and have children later but what existing literature fails to acknowledge is that the cost of living has increased and a household now requires two working adults to have a good quality of life now. Therefore women now feel like they have option but to delay motherhood.

When looking at the circumstances which cause women to delay pregnancy, current literature such as Mills et al (2011) often exclude the reality that women need to find the right partner to have a child with; which can be time consuming and it may only happen later in a woman’s life. Therefore women are often stigmatised for something which is out of their control. The respondents stressed:

*‘I think there are a lot of reasons why women are leaving having a child until later....for instance, travelling or having a job or not having the money or...NOT HAVING A PARTNER! That is something which the media and everybody else ignore! I think that is a big one because there are all these people who say women should have their babies young but I’m sorry...I didn’t get married until I was 29! How was I able to have children at 23 when I didn’t meet my husband until I was almost 26!’ – Jade.*

*'Maybe I would have liked to be slightly younger [when having first child] but I didn't meet my husband in time...I could have done it younger because I did have boyfriends and I could have done it on my own but I think that would have been selfish because it wouldn't have been right for the child. It would have been a struggle and it would have been with the wrong person.'* – Amy

It became apparent from the data that women are very cautious about having a child with the 'right' person and because finding a partner is time consuming, motherhood is often postponed. Despite the women in the research speaking of the matter so passionately, only very limited research touches upon the importance of finding the right partner 'in time' to have a child. Furthermore, men's involvement in decision making is often disregarded when exploring the 'right' time to have a child. Existing literature such as Leskošek (2011), focus on the timing of prospective motherhood like it is entirely a woman's responsibility. However, many women in this current research showed signs of anger and frustration as they argued that men do have an opinion regarding if and when they want a child, which can affect the timing in which women experience motherhood. Nina expressed how she felt about this during her interview and stated:

*'I think society tends to forget or what the media tends to forget when you read some articles, is that when talking about the average age of mothers is increasing and things like that is that men are involved in this process as well. It isn't just women sitting there making decisions for themselves and thinking about the perfect time to have a baby. Usually you are in a relationship with a man and it is up to him to think about if he's ready or not to have a baby. A lot of people forget that it is absolutely not just down to the women.'* – Nina

#### 4.4.2 Biological clock

The 'biological clock' was a subtheme which occurred throughout the interviews. A number of women believed that their choice regarding the timing of motherhood was restricted because of their biological clock. According to Selvaratnam (2014), the biological clock is a heterogeneous concept which represents the limited period of time within which a woman can conceive and start a family. The women expressed how they recognised their fertility declining as they got older. Isla, who was thirty-five and infertile due to previous medical conditions, was pregnant after her fourth cycle of IVF:

*'I am 35 now and I have noticed that I am getting older...from the first cycle I had 3 years ago when I had 17 eggs...the last cycle I had 6, so there is a huge difference - it definitely shows that the clock really is ticking now.'* – Isla

This particular theme was important in that it showed how the women's biological clock was reducing their chances of success throughout fertility treatments. Isla was the youngest

participant to be interviewed and the deterioration in the number of eggs she produced was a visual representation of her biological clock 'ticking'. This result corresponds with Human Fertilisation and Embryology Authority (2012), who acknowledged that the likelihood of becoming pregnant following assisted reproductive techniques reduces as a woman gets 'older'; with women aged thirty-five only having a 27.7% chance of successful pregnancy through fertility treatments. It can therefore be argued that 'older' women have limited choice regarding their reproductive timing due to biological limitations.

Similarly to Isla, the biological clock was also at the forefront of both Vicky and Katie's thoughts when considering the timing of having children:

*'I am not sure whether it was the biological clock ticking or that fact we were having fertility issues that I thought 'Yes I desperately want a child- and I want one now'. Also...I know a lot of men who have told their partners that they are not ready to commit yet and they kept putting off getting a house or getting married and then having a family and the women was always there saying like 'come on, we are running out of time here'. So I don't think women gamble with their fertility, I think maybe men gamble with women's fertility though.'* – Vicky

*'I think when I was in my 20's I didn't really think about having a baby but when the biological clock is ticking when you're in your 30's I think you do start to think about it. It's always in the papers how women's eggs deteriorate when they are over 30 and I think you become more aware of it. Women are constantly thinking about when they are going to have a baby because they are not like men...men don't think about it because they can get somebody pregnant at any time and they often risk a woman's fertility because they are in no rush.'* – Katie

The responses of the women highlighted that the biological clock is something which women sub-consciously think about as they get older. It could be argued that women are aware of their biological clock because they are afraid to lose the ability to have a child naturally. Women who view reproduction as a woman's primary role, are more likely to be aware of their biological clock declining and therefore carefully consider the timing of motherhood. Interestingly, the women emphasised the ideology that men risk women's fertility because male fertility declines at a much slower pace and is not something men are concerned about. Within existing literature there is an emphasis on women risking their infertility but the data from this current research shows that women are not solely to blame, as men also have a decision in the timing of pregnancy.

#### 4.4.3 Personal perspectives

Despite the women in this research not being fully in control of their own reproductive timing due to their own or their partners infertility, some of the women were very passionate about the age in which they think is 'right' to have a child. Lancet (2014), like many other theorists argues that women should have children young because they are more likely to have safer pregnancies and are much healthier and physically fitter to bring up a child. Kate was the only participant to favour younger mothers, despite being classified as an older mother herself:

*'I guess you think about getting older as well and think that you don't want to have a child too old because us (the parents) might not be around for our children... you have to think of the child and how old they are going to be when you die. So if you have given birth in your early 50's then you're going to be about 70 when that child is about 18. I just think that is very selfish. I don't think you are fit enough to cope with a child when your old anyway.'*

Kate's views were in line with Dann's (2014) theory which argues that women who delay motherhood may be viewed as selfish because there is a possibility that the child could lose one or both of their parents at an age where they are still very much dependant on them. Gill also believed that the potential risk of leaving young children behind is a difficult thought which older parents have to think about. However, the rise in life expectancy in Western countries has meant that the risk of losing a parent at a young age is no longer critical for most children born to 'older' parents today (Sutcliffe, 2012). This could be a potential reason why the majority of women in this research favoured 'older' motherhood. Despite Gill considering the fact those children born to 'older' mothers could be parentless at a young age; she still favoured 'older' motherhood:

*'...You might be perfectly fit and healthy. But then you have to think about that child. You know it could be parentless when they're five years old or something so that's quite a difficult one I think... I think older women are better [parents] though because they have more patience, than parents in their twenties - your mates are all still going out and having a bit of fun, but you cant. When you get older, your lifestyle changes and you don't want to go out - I want to stay in and watch the telly. You don't want to be partying every weekend' - Gill*

Gill believed that being an older mother is better because you are more focused on the child and have more patience. She suggested that having a child is demanding and suits the lifestyle of an 'older' person which Sutcliffe et al (2012) also argued. They pointed out that 'older' mothers have 'idealised' traits such as being caring and he viewed their less impulsive lifestyle as essential for good parenting (Sutcliffe et al, 2012). Along with the aspects of

physically coping and looking after a child as an 'older' mother, Vicky also mentioned how age affects fertility and how easily a woman conceives:

*'I think if you are younger then you have more time to try naturally and I would have had fewer drugs to stimulate my ovaries if I had IVF younger. When you are younger you have better fertility and I have to admit that being 38 and pregnant I kind of think 'oh god, I am already tired with one child, how am I going to manage two?' so if you are younger there is an advantage in terms of you are fitter to look after your kids. On the other hand, having waited longer we are financially secure and we can afford a lovely large family house and we can look after the children without having to worry about money. I can also have my full maternity off because I don't have to worry about loss of income and we are mature. We are in a stable relationship and we are more certain that it is going to last so there are pros and cons either way.'* - Vicky

She explains how younger mothers have better fertility which suggests they are 'idealised'. Furthermore, like the other women, Vicky also states that younger women are physically fitter than older mothers, which puts them at an advantage. However, she believed that the advantages of being an older mother outweighed the benefits of being a younger mother. She mentioned things such as being more financially secure and settled in a stable relationship where they don't have to worry about the loss of income during maternity leave. The ideology that older mothers are more 'prepared' for motherhood is in correspondence with Shaw and Giles' (2009) research as they argue older mothers tend to be more committed to the parenting experience as they have already established their life and are likely to be 'financially ready' to have children. Within this research it could be argued that the women's responses are biased as the majority of their views reflected their own experience. Despite some of the women openly admitting that they would have preferred to have children younger, they emphasised the benefits of having children older. Although Amy explains how she would not want to be any older:

*'I think 50 is pushing it. I mean, I am 45 and I wouldn't want to be any older. I often wonder how I am going to cope. From my perspective, I am going to be 60 when this child is still at school, so you know...you have to consider that. I am very unlikely to have Grandchildren, unless my children have them young...I think between 35 and 40 is best [to have a child] because you are old enough to have lived your life...the older you are the less likely you are to resent your child for preventing you from doing certain things. The older you get, the less likely you will feel like you are attached to your child and you need to be. It is very demanding and I am personally very glad I left it until I was older...Younger mother are less 'perfect' mothers on paper. When you are younger you do have energy but when you are older you can be totally focused on being a mother without wanting to do other stuff... Overall older mums have more time for children.'* - Amy

Amy was the anomaly of this research as not only was she oldest participant (aged forty-five), she was also the only participant to recommend having children younger than the age she was when she had a child. However, she believed the ages between thirty-five and forty are best to have a child. Therefore despite admitting she would have liked to have children younger, the ages she stated would have still been classified as 'old' to have a child within contemporary discourses of motherhood. She stated how demanding having a child is and suggested that this aspect of motherhood suit older mothers. This could be linked to existing research which focused on intensive mothering. Locke and Budds (2013) suggested that some women may prefer to delay having a child until the time is right for them because they are aware of the link between 'good mothering' and 'intensive mothering'. Amy suggested that older mothers have the time and patience to be 'intensive mothers', whereas younger mothers are less focused. However, Amy began stating how she is aware that she may never see her grandchildren because of the age in which she had children. This is in line with Carolan (2005) research which suggests women who are 'older' mothers fear that they will miss out on seeing their children growing up as well as missing out on grandchildren. She also questions 'how she will cope' in terms of looking after the children; which is in agreement to Shaw and Giles (2009) argument. They state how 'older' mothers are worried about their energy and coping ability. Despite the women stating the benefits of having children younger, they overwhelmingly focused on the positives to having children older. This contrasts with literature which states having children younger is positive (Lancet, 2014). The women's perceptions could be a result of society's norms changing as more women are having children later in life. The data suggested how younger mothers are 'too busy' to perform 'intensive mothering', which is linked to 'good mothering'. However, older mothers are in danger of missing their child grown up and likely to never meet their grandchildren (Carolan, 2005).

#### **4.5 Motherhood Mandate**

A theme which evidently ran throughout the data was Motherhood Mandate; which related to the women initially viewing motherhood as something which they believed was an inevitable experience. The data revealed that motherhood and becoming a mother was central to the respondents' lives and the sub-themes 'expectations', 'determination' and 'pressure' were all factors which influenced the women to have fertility treatments. Furthermore, there was a general consensus within existing literature and throughout the women's responses which viewed the decision to have children as a straightforward choice for women.

#### 4.5.1 Expectations

Ridgeway and Correll (2004) suggest that society internalises pronatalist ideology which indicates that motherhood is a gendered expectation for women. There have been many debates regarding the existence of pronatalist values, with some arguing that pronatalist views are outdated; however, the data in this current research were in line with Ridgeway and Correll's arguments. Eight of the women spoke about societal expectations in their interview and believed that family and friends in particular, expected the women to have children. Kate who was thirty-five suggested that people expect women who are married or in a long-term relationship to have a baby because it is the 'norm'.

*'I think if you are married or in long term relationships then I think people expect you to have a baby because that is what is seen as the norm in society. Generally there is an expectation for women to have a baby and I think people, especially family can't understand why you wouldn't want a child. It's becoming more acceptable not to have children now though. Before it was kind of frowned upon when people didn't have children and now it is becoming more acceptable than it was previously. I think older family members may think it is abnormal to be a woman in your thirties without a child, whereas your friends will think it is just normal as they also don't have children. So I guess it is down to social norms and how they have changed over the years and women are not prioritising having a family like they used to.'* - Kate

Despite Kate believing that there is an expectation in society for women to have children, she interestingly expressed how she thought these expectations were changing. She supported Dedeoglu's (2006) argument that being childfree is more acceptable now. Although Kate's friends also thought it was the norm to be childless, Kate revealed how 'older' members of her family viewed it as abnormal. This shows that older generations show a strong sense of adherence to existing norms and values and they find it difficult to adapt to changes in society. It could be interpreted that social norms have changed over the years and although there is still an expectation for women to have children, it is not as strong as it has been in the past. Therefore, this could imply that the ideology that women are expected to have children is becoming diluted and it could be predicted that eventually this societal expectation will be minimal. Vicky who was thirty-eight also mentioned in her interview that expectations and assumptions originate from the cultural norms.

*'I think the society expectation of women is to get married and have children and people tend to want family units. I know not everybody wants that and not everybody has the opportunity to have children but it is the cultural norm. Therefore, when you meet a woman who is in her their late 30's / 40's, you assume that she is probably a mother and statistically she probably*



*is. So I don't think society expects it in the sense that every women must have a child because that is the duty of women, rather they expect it because that is the norm of society.' – Vicky*

In opposition to Kate's views who thought that societal norms had changed, Vicky believed that these norms had remained the same. It could be interpreted that Vicky believed women who choose not to have children are deviating from cultural norms, which is in line with Doyle et al's (2012) argument. Similarly to Kate and Vicky, Lyndsay also recognises that there is a shift in society which has seen more women choosing not to have children.

*'I think society expects us to have children even though more women are choosing not to (have children) and that is a shift that is happening more. Although I don't think expectations are changing, I just think more women talk about it more. The power of media and the internet allows the voice of those women who don't want children to be heard. There have always been women who don't want children but 40 years ago people may have just presumed that they couldn't have children...' - Lyndsay*

Vicky believes that society expects women to have children because it is the cultural norm and argues that these expectations are not changing like Kate believed. Lyndsay agrees with Vicky and suggests that although expectations are there, more women are choosing not to have children. Therefore it could be interpreted that expectations remain and they can be passed down through generations. The data revealed that society still internalises pronatalist ideologies which fuels the expectations and the women believed that although such expectations were changing, an underlying expectation for women to have children remained. This was a thought-provoking finding as all of the women had or was going through fertility treatments at the time of the interview and although 'expectations of women' was not the reason why they were having treatment, it is thought it may have been a contributing factor.

#### 4.5.2 Pressure

A sub theme which clearly stood out across all the interviews was 'pressure'. Along with expectations, comes the pressure from society for women to have a child. When women internalise expectations they have strong beliefs which they pass on to family and friends. Park and Hill (2014) believe that there is an enormous amount of pressure on women to have children and this pressure is particularly distressing for women who have fertility problems. Kate who was thirty-five and the only participant who was unsure about having children explained the pressure she felt from those around her:

*'I guess I never really knew whether I wanted to have children or not but when your friends are having children around you, you start to think about it. When you get married, the first thing people say to you is 'when are you going to have a baby?' and the pressure starts*

*kicking in and the parents start asking all the time...then you start to think that you are not getting any younger so maybe we should start trying. I think there is a lot of pressure on women because they are the ones who have to carry and give birth.* - Kate

Kate suggested that her feelings towards having a baby changed once those around her started having children. This suggests that there is an unspoken expectation for women to have children and the actions of those around a person can influence a woman's decision to have a family. Kate expressed how she felt under pressure when people were asking her when she was going to be mother and she used the word 'should' as though it was her duty as a woman to have a child. In addition, Kate thought there was increased pressure on women to bear children because they are the ones who carry and give birth. Similarly, Nina also mentioned how she thought that women were unequal to men when it comes to reproduction, as women's fertility declines at a faster rate than a man's:

*'I think there is a lot of pressure for women. What I find upsetting is that you can be equal to men in so many areas of life but you can't be equal when it comes to having children. For example, there was a guy at work who had a child at 33 from a previous marriage and he said 'what age are you anyway, should you not be thinking about having children now?' He obviously didn't know I was trying and I just lost it with him. I just shouted at him and said 'do you actually want to know why?' and I told him that it's ok for men. They can turn round at the age of 50 and get a 30 year old girlfriend and have a baby if they want.'* - Nina

This indicates that the social pressure for women to have children is intensified as a consequence of their short fertile years. This is a new finding which existing literature has failed to acknowledge. Women are at the brunt of social expectations and experience a lot of pressure because they are the ones who carry the child and have limited years in which to have a natural pregnancy. Gill's experience was similar to Kates in that she experienced pressure as a result of observing those around her:

*'I think it's harder because I can see others are having children at an age that I'm at and I'm thinking that that's not happening to me and it adds more pressure. That is quite hard really. To see everyone else around me and it's just like 'they're having a baby, they're having a baby' and it's just in your face'* - Gill

Gill exerted more pressure on herself by comparing herself to others who were not infertile. However, women like Gill who are involuntary childless put added pressure on themselves because they view motherhood highly and have greater concerns regarding childlessness (McQuillan et al, 2008). Many of the women in this research expressed how the pressure to have a child was intensified once they got married:

*'The minute you get married or move in together, somebody will start presuming you're going to be having a baby and then the pressure starts' - Jade*

Furthermore, Nina explained *'I do think there is pressure on women to live up to the unspoken expectation that at some point they will have a baby.'* - Nina

Both Jade and Nina explain how there is pressure on women to have a child and live up to the 'unspoken expectation'. This further confirms that society still internalises pronatalist ideology and shows that pronatalist ideas are not outdated like Carroll (2012) argues. Furthermore, some of the respondents mentioned how they felt the pressure of being an 'older' woman without having a child and this may have also influenced the women's decisions to have fertility treatments. This corresponds with Schmidt's (2009) argument that involuntary childless women may feel pressure to fulfil their role as a child bearer and choose to have fertility treatments to increase their chances of becoming a parent.

#### 4.5.3 Determination

Throughout the interviews the majority of women showed a strong sense of determination to have children despite them or their partners being infertile. Within current literature, the infertility experience is documented as a very negative experience towards women and suggests that these women are often left feeling inadequate, angry, anxious and stressed (Greil, 2009). In contrast, it appears that infertility and the process of having fertility treatments has made the women in this research more strong, independent and resilient. Only one woman showed signs of giving up trying with fertility treatments and she eventually felt like she had no alternative but to see a counsellor. However, the other participant's responses represented strong characters that showed a sense of determination to become mothers. Fiona, who was thirty-nine and one of the oldest participants in this research, mentioned how determined she became after experiencing infertility:

*'Hmm...I had some issues early on with miscarriages so I felt like it almost became like a mission to get pregnant...we desperately wanted children.'* – Fiona

Fiona was not the only participant 'who desperately wanted children'. Amy, who was forty-five and on her eighth round of IVF stated that she was prepared to exhaust every method because she was so determined to have a child:

*'Well if somebody had said to me at the beginning of my fertility journey that I would be using donor eggs then I would have said, don't be so ridiculous. When you really want to have a baby, you try every method that could work...when a method gets exhausted then you always look for plan B. I wanted a child enough to use donor eggs...some people have said to me that*

*they just wouldn't have a child but that was not an option for me... I think possibly if I hadn't met my husband then I may have done it on my own anyway, but probably not until I was about 38/29.'* - Amy

Amy explained how she would have contemplated having children on her own if she was not with her husband; which showed huge determination. Having no children was not an option for Amy, Fiona and other respondents, which could be a result of many things. Varada (2011) argues that motherhood is an identity discourse which provides adult women with their primary identity, whilst reinforcing their gender roles. A woman's ability to conceive and bear children is perceived as vital for a woman's well-being (Inhorn, 2006). This could be a potential reason why these women are so determined to become a mother as without this identity, women can be seen as inadequate and worthless. Furthermore, these women may be determined to have a child as they want to fulfil society's expectations. However, Nina expressed in her interview how she thought the reasons why women exhaust all possibilities and want to try different fertility treatments is because of technology, which has increased the treatments that are available to them.

*'Nowadays they give you a diagnosis and they say well if you have this treatment you might just be able to have a child. So people now have this hope and know that they have to exhaust all possibilities that exist; which due to technology are now available to them, before they come to terms with the fact they may never have children. So basically they feel like they have to try all these options because if they don't they will live to regret it for the rest of their lives. That's the way I feel, I don't want to go through this shit... it's awful.'* - Nina

Nina believed that more advanced technology now gives women more 'hope' and women do not accept that they will be childless as easy as they did in the past. She also expressed how she was determined to try all the available treatments so that she did not live to regret. Martin (2010) suggests that infertile women believe fertility treatments are going to work and when they don't, it reinforces the ideology that they have failed to become a mother and that they may never be able to live up to the role of a woman. Nina's response was in line with Martin (2010), as she suggested that women find it difficult to accept that they have 'failed' to become a mother and therefore try a number of methods in hope of conceiving. Despite a lot of research focusing on the negatives of having fertility treatment, they fail to mention how obsessed and persistent they can make women; giving them hope and optimism about the possibility of having a child.

Some of the participants were so determined to have a child that they risked having twins. Both Gill and Jade had two embryos transferred in their treatment to increase their chances of

having a baby. Multiple births is the single biggest health risk associated with fertility treatments as the unborn babies in particular are more likely to be premature and have more health complications (HFEA, 2015). Both women knew and understood the increased risk of having twins but they were so engrossed with the prospect of having a child that they ignored the advice of health professionals. Gill stated:

*'I was excited because I was thinking I'm only going to have to do this once then. The first time was really exciting- I was not worried and I was not stressed about it. The fact that there may be two (babies) was brilliant. I couldn't have asked for anything better really.'* - Gill

Gill showed more signs of excitement than she did worry. She believed that the prospect of having two babies was ideal as she would only have to have fertility treatments once. Similarly, Jade also believed that the risk of having two babies is better than having none at all.

*'We always put 2 (embryos) back because I would rather have 2 babies than no babies... I always thought 'well it hasn't worked before so why would it work this time'...then it worked and we got a bit of a fright.'* - Jade

Both Gill and Jades views on having twins is a controversial argument as a woman's maternal instinct would be to look after the welfare of her unborn babies and herself. However, both of these women believe the risk of having two children outweighs the reality of being childless. This not only shows the determination of these two women to have a baby but it also rejects Degeoglu's (2009) ideology of 'good' mothering, as the women are not prioritising the needs of their children before their own. On the other hand, the risks of multiple embryo transfers are almost unavoidable and it is questionable whether the mother can be accused of being a 'bad' mother when her only intention was to fulfil her wish of becoming a mother. Mothers who have multiple pregnancies through natural conception are unlikely to experience this level of stigma and it is therefore unfair to accuse women who have had multiple embryo transfers to be 'bad' mothers. Many mothering discourses suggest that multiple embryo transfers are beneficial to women, as they increase women's chances of becoming a mother (Martin and Welch, 1998).

## **Chapter Five – Discussion**

This qualitative research study explored the views and experiences of fertility treatments among women over the age of thirty-five. The purpose of this research was to consider why ‘older’ women consider fertility treatments. It further sought to investigate ‘older’ women’s views on ART and aimed to locate the findings in context of discourses on contemporary motherhood. The study investigated ten women who were aged thirty-five or over who had been or were currently going through fertility treatments. These women were not all first time mothers and some of the women who had previous children had done so through natural conception or with help from fertility treatments.

Exploring the views and experiences of women enabled this research to explore the reality of having fertility treatments and the outcome this had on women’s thoughts and opinions. The interviewees placed a great importance on the facts of having fertility treatments as ‘older’ mothers, and in some instances, the findings of this research contradicted previous literature. The truths behind women using fertility treatments are often idealised by the media and many views are misconceived (Payne and Goedeke, 2007). It is often presumed that women rely on such treatments as a consequence of prioritising other commitments and it is thought that the family has become more of an option than a necessity (Chodorow, 2003). However, none of the women were relying on fertility treatments as a consequence of their own ‘selfish’ choice like Chodorow (2003) argued; rather they were having them as a result of their own or their partner’s infertility. Only one woman’s views corresponded with the majority of literature which states women rely on fertility treatments so they can be better educated and have a well-paid career, despite not purposely delaying motherhood herself (Friese et al, 2006). The remaining respondents were shocked and appalled to hear that some women may ‘gamble’ with their fertility and plan to use fertility treatments later in their lives. When discussing women’s increased involvement in education and the workplace, the women expressed how they believed this to be the reason why women in general are having children older, but they rejected it as a possible reason for why ‘older’ women are using fertility treatments (Smajdor, 2011).

There was an overall consensus throughout the data which suggested that women are aware and accepting of other women postponing motherhood, but there is stigma attached to those women who have fertility treatments as a result of purposely delaying childbearing. It could be argued that a woman’s perception on the reasons why other women have children older

change in relation to whether or not that woman has had fertility treatments. Existing literature assumes 'older' women have fertility treatments for the same reasons why they are 'older' mothers (Smajdor, 2011). However the women in this research expressed how a woman may be an 'older' mother because she delayed childbearing but she may be having fertility treatments because of her new partner's infertility. Therefore, the reason why women aged thirty-five or over have fertility treatments is not always inextricably linked to the reason why they are an 'older mother'. This is a new finding which has not been addressed by other researchers. In addition, statistics show that there are few women who have fertility treatments compared to the amount of women who choose to delay motherhood. Therefore, it cannot be presumed that all women who purposely delay motherhood will need medical assistance to conceive. Although it is acknowledged that there is a trend for women to have children older, women are not taking 'risks' with their infertility to the extent in which literature suggests (Smajdor, 2011) – as the majority are still able to conceive naturally. This data challenges arguments which suggest that 'older' women use fertility treatments as a result of purposely delaying motherhood (Smajdor, 2011)

When exploring the reasons why 'older' women have fertility treatments, infertility in the women was a prevalent theme. However, such infertility the women experienced was not age-related like Maheshwari et al (2008) presumed; rather they had all experienced previous long-term infertility which affected their timing of motherhood. This research therefore corresponds with the work of Berryman and Windridge (1991) who are amongst a very small amount of theorists who focus on 'older' mothers as a result of infertility, rather than women who 'risk' their fertility to be 'older' mothers. Furthermore, the majority of researchers focus on infertility in 'older' women as an inevitable biological experience and they often ignore that a woman may have been suffering with 'silent' infertility, in which they were unaware of and may have had for a number of years. It is therefore evident that much of the contemporary literature is channelled and sensationalised, which distorts the accuracy of the data and ignores the 'wider picture'. All of the women expressed how they had actively been trying for a number of years to conceive but the difficulties they had faced throughout the process meant they were older than they had initially planned. Therefore this research rejects the presumptions which suggest women are 'older' mothers by choice and highlights social circumstances as a multi-dimensional issue which affects a woman's choice regarding the timing of motherhood and whether or not she needs fertility treatments to conceive. Finally, the data revealed that 'older' women utilise fertility treatments appropriately and when

necessary which contradicts Forsyth (2009), who views assisted reproductive technologies as a process which is negative and a threat to our society.

According to the NHS (2014) men account for at least half of infertility cases globally. Despite this, the women expressed how male infertility is often underrepresented as a cause for women undergoing fertility treatments. From the sample, the few women who had IVF as a result of their partners infertility, expressed how medical staff misconceived the reasons why they were having treatment and presumed it was because they were experiencing infertility themselves. Unlike other theorists who often downplay male infertility, this research acknowledges male infertility as a credible reason for why women aged thirty-five or over undergo fertility treatments which meets one of the aims of this research.

Despite all the women in this research having fertility treatments as a response to their own previous ongoing infertility or their partners infertility, some of the women expressed how 'not having a partner' was a contributing factor to them being 'older' women going through fertility treatments. The women expressed how they may have had fertility treatment younger if they had met the 'right' supportive partner who would stick by them. Letherby (2013) is one of the few researchers to mention this in research. She suggested that some women are involuntary childless as a result of them not been in a stable relationship. Although this research is in line with Letherby's (2013) argument, the data recognised that the women were having infertility treatments for a number of contributing factors. This research differs from existing literature in that it understands the amount of time it can take a woman to find the right partner to have a child with. Furthermore, the timing of motherhood is predominately seen as a woman's responsibility and not only does society forget that a woman needs to meet somebody, but they also disregard the man's involvement in decision making. A man's opinion and contribution towards the timing of pregnancy is often unrepresented by theorists in current literature. These findings meets one the aims of this research which was to examine the reasons why 'older' women have fertility treatments.

This research aimed to explore women's views on fertility treatments and it was evident that the Human Fertilisation and Embryology Authority (2010) was right in stating that the medicalisation of infertility and the development of fertility treatments have provided infertile women with an opportunity to increase their chances of getting pregnant. Despite the women themselves viewing fertility treatments as a life-changing phenomenon which increased their reproductive choice, there was a correspondence throughout the interviews



which suggested that the topic of infertility and the use of fertility treatments are often perceived as taboo and something which are frowned upon by the rest of society. Furthermore, the women expressed how society is scared to confront people regarding the issues of being childless and infertile. Although this research did not examine the reasons why people are wary to ask questions, Woollett and Boyle (2000) argue that the use of fertility treatments can perpetuate the social norm of child bearing, which may cause the women to be judged and frowned upon by the rest of society, simply because it is the 'norm' to have a baby naturally. As a subject which is often hesitated to discuss openly due to the strong opinions that society attaches and the fragile feelings of those suffering, the women expressed how there is a lack of understanding surrounding the topic. All ten women believed that because of the private nature of infertility, many people, including medical staff, know very limited knowledge about infertility and fertility treatments. It was clear throughout the data that the women thoughts towards fertility treatments changed over the period of their infertility journey. Many of them began worrying about the prospect of having fertility treatments and explained how they were reluctant to undergo such treatments due to their lack of knowledge around the topic area. The data revealed that the women found it difficult to accept that they were no longer able to naturally conceive themselves and some of the women went to extreme lengths to try and avoid having treatment, by taking herbal remedies and having acupuncture in hope to boost their fertility. However, many of the women had experienced successful pregnancies and viewed fertility treatments very highly. They expressed how IVF allowed them to have a baby at an age in which they would not usually be able to naturally. The women understood the importance of following the correct procedures of the treatments and they were aware of the age-related decrease in the chances of fertility treatments working (Stoop, 2014). Despite some of the women experiencing unsuccessful treatments, they still expressed how 'lucky' they were to be able to have the treatment initially.

The women believed that fertility treatments have given infertile 'older' women more hope as they have provided women with more options to help with their conception. However, the women explained how the advancement of fertility treatments has meant that women find it necessary to exhaust all options before accepting they are childless. Some of the women expressed the emotional effect of having numerous unsuccessful treatments. The feelings the women mentioned were similar to those Greil (2009) documented in his research. He suggested that when women have a negative experience of fertility treatments, they are often

left feeling inadequate, angry, anxious and stressed (Greil, 2009). Although Brandes et al (2011) believe the biggest risk associated with fertility treatments is the possibility that the procedure may not work, many theorists ignore how determined they can make women and how controlling they can be on women's lives.

The data brought to light that fertility treatments are not an easy option for women as they are a process which requires a lot of time, money and dedication. Furthermore, it was revealed that 'older' women may feel disadvantaged when accessing fertility treatments as some clinics in the UK have age limits as low as thirty-five because the chances of success are lower from that age. The women who already had children expressed how they were declined treatment by the National Health Service and therefore had to pay privately for their treatment, which corresponds with Jenkins et al (2003) theory. As Mclean (2003) suggests, women have to 'fit a criteria' to be eligible for treatment on the National Health Service. The majority of women in this research failed to meet such criteria and were 'forced' to pay privately to have treatment. Despite some of the women being financially able to pay for numerous cycles of IVF, others were unable to start a fresh cycle until they had saved enough money to cover the costs of the treatment. This demonstrates how fertility treatments carried out privately are only accessible to those fortunate enough to have the resources to pay for the treatment (Pennings and Mertes, 2010). Throughout the interviews, the women expressed how they thought treatments should be based on an individual's health and circumstances rather than generalisations.

The women reported throughout the interviews that the need to have and want children came from the norms and expectations of society. Previous research suggests that for women, motherhood is a gendered expectation and is viewed as necessary (Ridgeway and Correll, 2004). Similarly, the women revealed how motherhood and becoming a mother was central to their lives. Furthermore, within contemporary literature there is an ongoing debate surrounding motherhood and whether or not it is something which is rooted in biology (Broekmans, 2007) or something which is social constructed and embedded in society's norms and values (Varada, 2011). Within this research, nine of the women believed that the desire to have a child was inbuilt and a natural life progression. However, eight of the ten women also spoke about societal expectations and believed that family and friends in particular expected them to become mothers. Although some women expressed how they felt expectations were changing and weakening, the data still revealed how motherhood can be socially constructed. Therefore, this research shows how motherhood can be both biological

and a social construction which does not resolve the existing controversy in the literature. However, it was revealed that motherhood is a gendered expectation and it is believed that women in society still internalise pronatalist ideologies which is in line with Carroll's (2012) Research. This would therefore explain the enormous pressure the women felt to have children and explains the emotional difficulties that they faced when they first encounter infertility, as well as experiencing failed IVF cycles. This finding meets two of the aims of this research which were to locate the findings in context of discourses of contemporary motherhood and to explore the reasons and motivations which cause women aged thirty-five and over to have fertility treatments.

It is argued that women in particular experience pressure when they internalise the expectations of society (Carroll, 2012). Chambers (2012), debates that this is because women are the ones who carry and give birth to the baby. Although this may be a contributing factor, the data revealed it was because women have limited years in which to have a natural pregnancy. Although a woman's 'biological clock' is often debated within literature, the effect it has on a woman is rarely documented. Within this research, it was prominent that women were under increased social pressure to have a child because they were aware that their fertile years were very short. Some women expressed how before they had fertility treatments, they felt under pressure to have children by a certain age because they knew their fertility would decrease. In addition, the women explained how this pressure increased once they had passed the optimum age to have a child because they knew the likelihood of getting pregnant naturally or through fertility treatments decreases the older a woman gets. The women stressed how this pressure was intensified as friends and family were having children around them. The theory that women are under constant surveillance by others to fulfil the role of a mother is something which has been documented on a number of occasions. However, the ideology that this pressure is magnified as a result of women's limited fertile years is a new finding which other research has failed to acknowledge.

The overall impression of the data was that the women viewed older motherhood as a positive entity as opposed to the literature which overwhelmingly categorised these women as 'selfish mothers' (Lee and Gramotnev, 2006). Such literature and media articles are heavily focused on the risks associated with older mothers and their unborn child. For instance Maheshwari et al (2008) and Bongaarts (1982) argue that as a woman reaches her mid-thirties, her chance of conceiving decreases, whilst the chance of miscarriage increases. In addition, the quality of her eggs decline and this decline is dramatically increased once she

reaches the age of forty (Craft, n.d). Furthermore, Brethrick et al (2012) suggests that women over the age of thirty-five are more at risk of having stillbirths, preterm births, ectopic pregnancies and babies with chromosomal abnormalities. However, within this research, surprisingly no participants acknowledged these risks as they were too focused on the positives of having a child later in life. The reason for this could be because the media views older mothers from a macro level and can sometimes exaggerate and sensationalise information, whereas the women in this study based their opinion on their own positive experiences. In addition, the women within this study believed the opportunity to have a child outweighed the potential risks.

Dominant discourses of motherhood are hegemonic enough to eclipse data indicating that 'older' mothers are not 'good mothers' as they have not got the energy or coping abilities which are necessary when looking after a young child (Shaw and Giles, 2009). They suggest that 'older' mothers are likely to leave their children when they pass away and run the risks of not being a grandparent (Dann, 2014). Although the data revealed that women did acknowledge these disadvantages of being an 'older' mother, the women focused more on how being 'older' was more suitable to 'intensive' mothering. In relation to their age and having successful IVF cycles, the women mentioned how they were 'better' equipped for motherhood as they were more financially secure, in a stable relationship and had more leisure time to spend with a child (Sutcliffe et al, 2012). Through discourses of 'good' mothering, society is led to believe that a good mother puts the needs of the child before her own (Christopher, 2012). However, the women in this research who risked having twins by having two embryos transferred, rejected discourses of good mothering as they put the needs of their own before their child/children's health. This data shows how some women may get caught up in the prospect of having a biological child and become so determined that they believe the need to have a baby, outweighs any risks associated with having twins.

## Chapter Six – Conclusion

Conclusions overall were drawn from the analysis of the ‘lived’ experiences of ‘older’ mothers and their perceptions of fertility treatments. It will be highlighted how this research has enabled a further understanding of women aged thirty five or over who use ART.

The impression of previous literature was that they overwhelmingly portrayed fertility treatments as a negative phenomenon. Theorists overwhelmingly centred their debates on the risks associated with having fertility treatments later in life and the poor success rates. In addition, there was an overall consensus which believed the development of ART had encouraged ‘older’ mothers as women view it as a method in which they can ‘rely’ on to conceive. However, the Office for National Statistics (2013) show that although fertility treatments do contribute to the increase in mean age of giving birth and the rising fertility rates among ‘older’ women, they are not the only reason. The data from this research corresponds with this and suggests that ‘older’ mothers use fertility treatments as a result of social norms and expectations changing. However, circumstances such as their own or partners infertility, not having the right partner, NHS waiting lists, partner’s views on the timing of pregnancy and financial stability were also factors which contributed to women being ‘older’ when they used fertility treatments. The data revealed that ‘older’ women utilise fertility treatments appropriately and when necessary and therefore rejects the presumptions made by other theorists who suggest ‘older’ women use fertility treatments as a result of purposely delaying motherhood and relying on assisted reproductive technologies. Therefore, the aim to find why women aged thirty-five or over use fertility treatments were met and the outcomes conflicted with existing literature.

Furthermore, it was the aim of the research to locate the findings in context of discourses on motherhood. The research began by demarcating the pronatalist discourse and debating whether women still internalise pronatalist ideologies. From the findings, it can be suggested that a woman’s decision to have fertility treatments is upheld by the social biases of pronatalism and although the women did not out-rightly state they had fertility treatments for this reason, they did emphasise how cultural and gender expectations influenced their decision to have them. The women viewed motherhood as an identity discourse which they viewed as necessary. This exerted a lot of pressure on the infertile women to bear children through fertility treatments and to live up to the ‘role’ of a woman.

The data from this research rejects dominant discourses on motherhood which suggests 'older' mothers are not 'good' mothers. The ideology that some of the women have continued to have fertility treatments despite numerous failed cycles shows a strong sense of commitment and dedication to motherhood. The women were self-consciously committed to child rearing as they expressed how they were financially secure enabling them to have full maternity leave, they were in a stable relationship where they had additional support and they prepared to give-up their leisure time to be with the child. Despite been criticised within the media and existing literature, 'older' mothers are well prepared for 'intensive mothering'.

The final aim of this study was to explore the views and perceptions of women aged thirty-five and over who have been through fertility treatments. It was refreshing to hear how highly the women viewed reproductive technologies and to hear the positive effects that such treatments had on women's lives. It does not go unmentioned that fertility treatments can be financially, physically and emotionally draining for women, but the women expressed how the potential rewards of the treatment outweighed the negatives. Although the women believed they were disadvantaged when accessing the treatments, as a result of their age, they all acknowledged and appreciated that the treatment enabled them to try for a baby at an age they would usually struggle to naturally conceive.

This research viewed reproductive technologies from a different perspective as it was brought to light through examining women's actual experiences that such treatments are a positive to infertile 'older' women, as they allow them to conceive, carry and give birth to their own child. Radical feminists critique the medicalisation of reproduction and the patriarchal influences attached to medicalisation. However, liberal feminist highlight how various fertility treatments are valuable to women as they can benefit from having more choice over their reproduction. Despite viewing such treatments as positive, the data revealed how repeated failed IVF cycles can hinder a woman's reproductive autonomy and psychological wellbeing. However, from a post-modern feminist perspective, fertility treatments can – when successful - alleviate the pressures of being childless. Treatments such as intracytoplasmic sperm injection (ICSI), Preimplantation genetic diagnosis and egg sharing are still in their infancy (Gürtin et al, 2012) and by going forward there will be opportunity to re-visit the data using a lens from a different feminist perspective; thus providing an opportunity to delve deeper into the experiences of 'older' women who use fertility treatments.

In meeting the aims of this research and giving these women the opportunity to voice their personal experiences; it has in turn enabled a further and clearer understanding of the ‘older’ women’s perceptions of fertility treatments.

### 6.1 Contributions

The study makes an original contribution to the social sciences regarding the perceptions of ‘older’ women who have undergone fertility treatments. It was anticipated that by conducting research in this context it would also contribute to existing literature surrounding the topic area. However, the research is unique in that it focuses on the social aspects of fertility treatments rather than the medical implications. Women’s experiences are at the heart of this research and therefore may be of interest to current policy makers.

There is an ongoing debate regarding ‘Fertility health’ and whether or not it should be taught in secondary schools. Fertility treatments such as IVF may currently be taught in schools in relation to ethics or technological advancements but the experience of such treatments are often ignored. The women in this research emphasised the importance of giving more information to young girls regarding their fertility and to, where possible, prevent infertility in the future. Therefore this research could potentially be used within education to inform pupils of infertility and the social aspects of having fertility treatments.

### 6.2 Limitations

Despite the richness of the findings and notwithstanding the original contributions this research claims to make, there were some limitations to the research. Firstly, the respondents had similar demographics as they were all white British women, aged thirty-five or over and from middle class backgrounds. The study failed to recruit any women who were single or in a same sex relationship and whilst this was not the aim of this research, it was simply a result of the accessibility of participants. Although self-selected sampling via a social media website was a successful method of recruiting participants, the same ‘type’ of people came forward for this research. Furthermore, women who may not have had regular internet access may have been excluded from participating. A consequence of this research not being specific when recruiting participants meant that there were some women who were going through fertility treatments as a result of their own infertility and others were doing so because of their partners’ infertility. Some of the women in this research were having fertility

treatments in hope to be a first time mother, whereas others had previous children; whether or not this is a limitation to the research could be open to debate.

The purpose of this research was to create a deeper understanding of the views and experiences of fertility treatments among women aged thirty-five or over. Whilst the findings of this research did meet this objective, they are not intended to be applied to all women over thirty-five who have been through fertility treatments. Although feminist would favour the small sample utilised within this research, the findings are only specific to the women in this study and therefore cannot be generalised.

### 6.3 Recommendations for future research

This research has opened up many other avenues for further study. As a research project which only focused on women's views and experiences, it would be interesting and beneficial to explore men's perceptions too.

It was deeply fascinating to see how the women in this research constructed their views and opinions based on their experience of using fertility treatments. Despite many of the women stating that they wanted children younger, the majority of the women glorified the situation of either being an 'older' mother or being an 'older' women trying for a baby. It would be therefore prudent to investigate women of different ages to determine whether they have gone through a similar process. In addition, it would improve the representativeness of the sample if the participants belonged to different ethnic and social class backgrounds. Doing this would give a more in-depth understanding about the views and experiences of fertility treatments.

When examining existing literature and carrying out this research it was highlighted that close attention needs to be given to those women who have long term medical conditions which cause them to have fertility treatments. There is a huge emphasis on women purposely delaying motherhood and 'choosing' to use fertility treatments but little research is carried out on those women who did not anticipate using them. In addition, an in-depth review of women who undergo fertility treatments as a result of their partner's infertility would fill a gap in research, as well as a research study carried out on those women who experience numerous failed IVF cycles and have to accept they may never be biological parents.

Finally, it may be beneficial to carry out a content analysis of the literature used in media articles. This would develop an insight into the way in which media portray fertility



treatments and would provide an opportunity to determine the extent to which they sensationalise information and exaggerate the truth surrounding the use of them.

## References

- Abrams, L. (2010). Sampling 'Hard to Reach' populations in Qualitative Research. *Qualitative Social Work*. 9 (4), 536-550.
- Allen, M. (2011). Violence and Voice: using feminist constructivist grounded theory to explore women's resistance to abuse. *Qualitative Research*. 11 (1), 23-45.
- Arendell, T. (2000). Conceiving and Investigating Motherhood: The Decades's Scholarship. *Journal of Marriage and Family*. 62 (4), 1192-1207.
- Bell, K. (2013). Constructions of 'infertility' and some lived experiences of involuntary childlessness. *Journal of women and social work*. 28 (2), 284-295.
- Baird, D. Collins, J. Egozcue, J. (2005). Fertility and Ageing. *Human Reproduction*. 11 (3), p261-276.
- Becker, G. (1994). Metaphors in Disrupted Lives: Infertility and Cultural Constructions of Continuity.
- Benzies, K.M. Allen, M.N.. (2006). Symbolic interactionism as a theoretical perspective for multiple method research. *Journal of advanced nursing*. 33 (4), 541-547.
- Berg, B. (2009). *Qualitative Research Methods*. London: Pearson Education Ltd.
- Boivin, J. Rice, F. Hay, D. Harold, G. Lewis, A. Thapar, A. (2009). Associations between maternal older age, family environment and parent and child wellbeing in families using assisted reproductive techniques to conceive. *Social science and Medicine*. 68 (11), p948-1955.
- Bongaarts, J (1982) 'Infertility after age 30: a false alarm' *Family Planning Perspectives*, 14, pp.75-78.
- Brandes, M. Verzijden, J. Hamilton, C. de Ways, N. Bruin, J. Bots, R. Nelen, W. Kremer, J. (2011). Is the fertility treatment itself a risk factor for early pregnancy loss?. *Reproductive BioMedicine*. 22 (1), 192-199.
- Brethrick, K., Fairbrother, N., Avila, L., Harbord, S. and Robinson, W. (2012). "Fertility and aging: do reproductive-aged Canadian women know what they need to know?" *Fertility and Sterility* 93, 2162-2168.
- Braun, V. Clarke, V. (2006). Using Thematic analysis in psychology. *Qualitative research is Psychology*. 3 (2), 77-101.
- Bryman, A. (2012). *Social Research Methods*. 4th ed. London : Oxford University Press.
- Burnard, P. Gill, P. Stewart, K. Treasure, E. Chadwich, B. (2008). Analysing and presenting qualitative data. *British Dental Journal*. 204 (1), 429-432.

Campbell, D. (2014). *Women who postpone having babies may stay childless, warns medical chief*. Available: <http://www.theguardian.com/society/2014/jan/17/women-postpone-babies-childless-medical-chief>. Last accessed 29th Oct 2014.

Carolan, M. (2005). 'Doing it properly': The experience of first mothering over 35 years. *Health Care for Women International*, 26, 764–787

Carolan, M.C., Davey, M., Biro, M. & Kealy, M. (2013) "Very advanced maternal age and morbidity in Victoria, Australia: A population based study", *BMC Pregnancy and Childbirth*, vol. 13.

Carroll, L. (2012). *The Baby Matrix: Why Freeing our minds from outmoded thinking about parenthood and reproduction will create a better world*. London: LiveTrue. 1-10.

Chambers, G.. (2012). A reduction in public funding for fertility treatment - an econometric analysis of access to treatment and savings to government. *Health service research* . 12 (8), 1186-1472.

Christopher, K. (2012). Extensive Mothering: Employed Mothers' Constructions of the Good Mother. *Gender and Society*. 26 (1), 73-96.

Collins, J. Crosignani, P. (2005) Fertility and ageing. *Human reproduction Update*. 11 (1), p261-276.

Conrad, P. and Schneider, J.W. (1980) *The Medicalisation of Deviance: From Badness to Sickness*. St Louis, MO: Mosby.

Cowan, M. (2011). Fail to Succeed. *Wired*, May 2011, p90-101.

Craft, I (no date) 'Fertility in the Older Aged Woman'  
[http://www.infertilitynetworkuk.com/uploadedFiles/Resources/Factsheet\\_storage/Fertility%20in%20the%20Older%20Woman.doc](http://www.infertilitynetworkuk.com/uploadedFiles/Resources/Factsheet_storage/Fertility%20in%20the%20Older%20Woman.doc) [Accessed 10th June 2016]

Culley, L. Hudson, N. Rapport, R. Blyth, E. Norton, W. Pacey, A. (2011). Crossing borders for fertility treatment: motivations, destinations and outcomes of UK fertility travellers. *Human Reproduction*. 26 (9), 2373-2381.

Curtis, B. Curtice, C. (2011). *Social Research: A Practical Introduction*. London: SAGE Publications Ltd.

Cussins, C. (1996). Ontological choreography: Agency through objectification in infertility clinics. *Social Studies of Science*, 26(3), 575-610.

Dane, F. (2011). *Evaluating Research*. London: SAGE publications.

David, M. Sutton, C. (2004). *Social Research*. London: Sage publications

- David, M. Sutton, C. (2011). *Social Research: An Introduction*. 2nd ed. London: SAGE Publications Ltd.
- Dechanet, C. Anahory, T. Daude, M. Quantin, X. Reyftmann, L. Hamamah, S. Hedon, B. Dechaud, H. (2011). Effects of cigarette smoking on reproduction. *Human Reproduction*. 17 (1), p76-95.
- Dedeoglu, A. (2006). Discourses of Motherhood and Consumption Practices of Turkish Mothers. *Gender Marketing and Consumer Behaviour*. 4 (1), 54-62.
- Deka, P.K. Sarma, S. (2010). Psychological aspects of infertility. *British Journal of Medical Practitioners*. 3 (3), 336-340.
- Dickson-Swift, V. James, E. Kippen, S. Liamputtong, P. (2007). Doing sensitive research: what challenges do qualitative researchers face?. *Qualitative Research*. 7 (3), p327-353.
- Donley, A. (2012). *Sociology: Research Methods*. London: Facts On Fire.
- Dowling, M. Tuohy, D. Cooney, A. Murphy, K. Sixsmith, J. (2013). An overview of interpretive Phenomenology as a research methodology. *Nurse Researcher*. 20 (6), 17-20.
- Doyle, J. Pooley, J. Breen, L. (2012). A Phenomenological exploration of the childfree choice in a sample of Australian women. *Journal of health psychology*. 18 (3), 397-407.
- Fairclough, N. (2001). *The Dialectics of Discourse*. Available: <http://www.ling.lancs.ac.uk/staff/norman/200>. Last accessed 23rd July 2015.
- Ferraretti A, Pennings G, Gianaroli L, Natali F, Magli MC. (2010) Cross-border reproductive care: a phenomenon expressing the controversial aspects of reproductive technologies. 20: 261 – 266.
- Flick, U. (2009). *An Introduction to Qualitative Research*. 4th ed. London: SAGE.
- Forsythe, S. (2010). Social Stigma and the Medicalisation of Infertility. *Open Journal*. 28 (1), P22-36.
- Friese, C. Becker, G. Nachtigall, R.D. (2006). Rethinking the biological clock: eleventh-hour moms, miracle moms and meanings of age-related infertility. *Social Science and Medicine*. 63 (6), 1550-1560.
- Greil, A.L. Slauson-Blevins, K. McQuillan, J. (2010). The experience of infertility: a review of recent literature. *Sociology of Health and illness*. 32 (1), 140-162.
- Gürtin, Z. Ahuja, K. Golombok, S. (2012). Emotional and relational aspects of egg-sharing: egg-share donors' and recipients' feelings about each other, each others' treatment outcome and any resulting children. *Human Reproduction*. 0 (0), 1-12.

- Gurunath, S. Pandian, Z. Anderson, R. Bhattacharya, S. (2011). Defining infertility - a systematic review of prevalence studies . *Human Reproduction*. 17 (5), p575-588.
- Hammarberg, K., & Clarke, V. E. (2005). Reasons for delaying childbearing. *Australian family physician*, 34, 187-189.
- Hammons, S. (2008). Assisted reproductive Technologies: Changing conceptions of Motherhood?. *Affilia*. 23 (3), 270-280.
- Harding, S. (1993) 'Rethinking Standpoint Epistemology: "What is Strong objectivity"?' in L. Alcoff and E. Potter (eds), *Feminist Epistemologies*. New York: Routledge.
- Henn, M. Weinstein, M. Foard, N. (2008). *A short introduction to Social Research*. London: SAGE publications.
- Hesse-Biber, Sharlene Nagy. (2014). *Feminist Research Practice: A Primer*. London: SAGE publications.
- Homan, G. Davies, M. Norman, R. (2007). The impact of lifestyle factors on reproductive performance in the general population and those undergoing infertility treatment: a review. *Human Reproduction*. 13 (3), p209-233.
- Hope, J. (2012). *Children of mothers 'over 40 are healthier and more intelligent and less likely to have accidents'*. Available: <http://www.dailymail.co.uk/health/article-2147848/Children-mothers-40-healthier-intelligent.html>. Last accessed 19th Aug 2015.
- Human Fertilisation and Embryology Authority. (2001). *How legislation on fertility treatment developed*. Available: <http://www.hfea.gov.uk/1319.html>. [Last accessed 13th June 2016].
- Human Fertilisation and Embryology Authority. (2010). *Latest UK IVF figures: 2010 and 2011*. Available: <http://www.hfea.gov.uk/ivf-figures-2006.html>. [Last accessed 13th June 2016].
- Human Fertilisation and Embryology Authority. (2012). *HFEA releases third report on fertility trends*. Available: <http://www.hfea.gov.uk/8828.html>. [Last accessed 10th June 2016].
- Human Fertilisation and Embryology Authority. (2013). *Fertility Treatments in 2013: Trends and Figures*. Available: [http://www.hfea.gov.uk/docs/HFEA\\_Fertility\\_Trends\\_and\\_Figures\\_2013.pdf](http://www.hfea.gov.uk/docs/HFEA_Fertility_Trends_and_Figures_2013.pdf). [Last accessed 10th June 2016].
- Human Fertilisation and Embryology Authority. (2014). *Multiple births in the UK - statistics*. Available: <http://www.hfea.gov.uk/6456.html>. [Last accessed 13th June 2016].
- Human Fertilisation and Embryology Authority. (2015). *NHS fertility Treatment*. Available: <http://www.hfea.gov.uk/fertility-treatment-cost-nhs.html>. Last accessed 5th March 2015.

- Inhorn, M.C. (2006) Defining Women's Health: A Dozen Messages from More than 150 Ethnographies. *Medical Anthropology Quarterly* 20(3): 345-378.
- Inhorn, M. Patrizio, P. (2015). Infertility around the globe: new thinking on gender, reproductive technologies and global movements in the 21st century. 21 (4), p441-426.
- Jarvie, R. Letherby, G. Stenhouse, E. (2015). 'Renewed' 'older' motherhood/mothering: a qualitative exploration. *Journal of Women aging*. 27 (2), 103-122.
- Jenkins, J. Corrigan, L. Chambers, R. (2003). *Infertility Matters in Healthcare*. Oxon: Radcliffe Medical Press Ltd.
- Jolly, M. Sebire, N. Harris, J. Robinson, S. Regan, L. (2000). The risks associated with pregnancy in women aged 35 years or older . *Human Reproduction*. 15 (11), 2433-2437.
- Katz, P. Showstack, J. Smith, J. Nachtigail R. Millstein, S. Wing, H. Eisenberg, M. Pasch, L. Croughan, M. Adler, N.. (2011). Cost of infertility treatment: Results from an 18-month prospective cohort study. *Fertility sterilasation*. 95 (3), 915-921.
- Kim, Y. (2011). The Pilot Study in Qualitative Inquiry. *Qualitative Social Work*. 10 (2), 190-206.
- King, N. Horrocks, C. (2010). *Interviews in Qualitative Research*. London: Sage Publications.
- Kraaij, V. (2009). Coping, Goal adjustment and positive and negative affect in definitive infertility. *Journal of health psychology*. 14 (1), 18-26.
- Lancet. (2014). Fertility: progress and uncertainty. *The Lancet*. 384 (9950), 1237.
- Landman, M. (2006). Getting quality in qualitative research: A short introduction to feminist methodology and methods. *Proceeding of the Nutrition Society*. 65 (1), 429-433.
- Lampinen, R. Vehviläinen-Julkunen, K. & Kankkunen, P. (2009). A review of pregnancy in women over 35 years of age. *The Open Nursing Journal*, 3, 33–38.
- Lee, C. Gramotnev, H. (2006). Motherhood Plans among young Australian Women: Who wants children these days? *Journal of health psychology*. 11 (1), 5-20.
- Leskošek, V. (2011). Historical Perspectives on the Ideologies of Motherhood and its impact on Social Work. *Social Work and Society International Online Journal*. 9 (2), 1-9.
- Letherby, G. (2010). challenging Dominant Discourses: Identity and change and the experience of 'infertility' and 'involuntary childlessness'. *Journal of Gender Studies*. 11 (3), 277-288.
- Lewis, M. Staehler, T. (2010). *Phenomenology: An Introduction*. London: Continuum International Publishing Group.

- Liamputtong, P. Ezzy, D. (2005). *Qualitative Research Methods*. London: Oxford Press.
- Lock, A. and Budds, K. (2013) 'we thought if it's going to take two years then we need to start now': Age, infertility risk and the timing of pregnancy in older first-time mothers'. *Health, Risk and Society*, 15, p525-542.
- Lord, J. Shaw, L. Dobbs, F. Acharya, U. (2001). A time for change and a time for equality - Infertility services and the NHS. *Human fertility*. 4 (4), 256-260.
- Lotz, Amanda D. (2003) Communicating third-wave feminism and new social movements: challenges for the next century of feminist endeavor. *Women and Language*. 26 (1) p2-8
- Marshall, C. and Rossman, G. B. (1999) *Designing Qualitative Research*, 3rd ed. Thousand Oaks, CA: SAGE. Maynard, M. Purvis, J. (2005). *Researching Women's lives from a feminist Perspective*. 5th ed. London: Taylor and Francis.
- Martin, L. (2010). Anticipating Infertility: Egg Freezing, Genetic Preservation, and Risk. *Gender and Society*. 24 (4), 526-545.
- Martin, M. Welch, H.. (1998). Probabilities for singleton and multiple pregnancies after in-vitro fertilisation. *Fertility and Sterility*. 70 (1), 478-481.
- Maheshwari, A. Hamilton, M. Bhattacharya, S. (2008). Effect of female age on the diagnostic categories of infertility. *Human Reproduction*. 23 (3), 538-542.
- Maheshwari, A., Porter, M., Shetty, A. and Bhattacharya, S. (2008). 'Women's awareness and perceptions of delay in childbearing.' *Fertility and Sterility* 90, 1036-1042
- Marino, J.L. Moore, V. Rumbold, A.R. Michael, D. (2010). Fertility treatments and the young women who use them: an Australian cohort study. *Human Reproduction*. 10 (0), 1-7.
- McQuillan, J. Torres-Stone, R. (2007). Infertility and Life Satisfaction Among Women. *Journal of Family Issues*. 28 (7), p955-981.
- McQuillan, J. Greil, A. Shreffler, K. Tichenor, V.. (2008). The importance of motherhood among women in the contemporary United States. *Gender and Society*. 22 (4), 477-496.
- McQuillan, J. Griel, A. Shreffler, K. Wonch-Hill, P. Gentzler, K. Hathcoat, J. (2012). Does the reason Matter? Variations in Childlessness concerns among U.S Women. *Journal of Marriage and Family*. 74 (5), 1166-1181.
- McTernan, E. (2014). Should Fertility Treatment be State Funded? *Journal of Applied Philosophy*. 32 (3), 227-240.
- Mills, M. Rindfuss, R. McDonald, P. (2011). Why do people postpone parenthood? Reasons and social policy incentives. *Human Reproduction Update*. 0 (0), 1-13.
- Mollen, D. (2006) Voluntarily childfree women: Experiences and counseling considerations. *Journal of Mental Health Counseling* 28: 269–282.

Morison, T. (2013). What to expect when you're not expecting: Child-freedom, social stigma, and online subjectivities. Paper presented at International Society of Critical Health Psychology 8th Biennial Conference, 22 – 24 July, Bradford, United Kingdom.

Neal, M. (2011). Protecting Women: Preserving Autonomy in the Commodification of Motherhood. *William and Mary Journal of Women and the Law*. 17 (3), 611-637.

Neuman, W.L (2011). *Social Research Methods*. 7th ed. London: Pearson.

NHS. (2014). *Infertility*. Available:  
<http://www.nhs.uk/conditions/infertility/Pages/Introduction.aspx>. Last accessed 3rd Nov 2014.

NHS. (2014). *Risks of infertility treatment 'overhyped'*. Available:  
<http://www.nhs.uk/news/2014/01January/Pages/Risks-of-infertility-treatments-overhyped.aspx>. Last accessed 11th March 2015.

Nomaguchi, K. Milkie, M. (2003). Costs and Rewards of children: The effects of becoming a parent on adults' lives. *Journal of Marriage and Family*. 65 (2), 356-374.

Oakley, A. (1998) 'Gender, Methodology and People's Ways of Knowing: Some problems with feminism and the Paradigm debate in social science', *Sociology*, 32 (4): 7070 – 32.

Pandian, Z. Bhattacharya, S. (2013). IVF for unexplained infertility. *Human Reproduction*. 19 (5), p431.

Park, N. K. Hill, P. (2014). Is adoption an Option? The Role of importance of Motherhood and Fertility Help-Seeking in Considering Adoption. *Journal of Family Issues*. 35 (5), 601-626.

Parker, I. (2005). *Qualitative Psychology: Introducing Radical Research*. Berkshire: Open University Press.

Parry, D. C. (2005). Women's leisure as resistance to pronatalist ideology. *Journal of Leisure research*, 37, 133-151.

Payne, D. and Goedeke, S. (2007). Holding together: Caring for clients undergoing assisted reproductive technologies. *Journal of advanced nursing*. 60 (6), 645-653.

Quinn, D. M., Chaudior, S.R. (2009). Living with a concealable stigmatised identity: The impact of anticipated stigma, centrality salience and cultural stigma on psychological distress and health. *Journal of personality and social psychology*. 97 (1), 634-651.

Remennick, L. (2000). Childless in the Land of imperative motherhood: Stigma and Coping Among Infertile Israeli Women. *Sex Roles*. 43 (12), 820-821.

Ridgeway, C. Correll, S. (2004). Motherhood as a status characteristic. *Journal of Social Issues*. 60 (4), 3-9.



- Ritchie, J. Lewis, K. McNaughton Nicholls, C. Ormston, R. (2014). *Qualitative Research Practice*. London: SAGE publications.
- Schiebinger, L. (2003). Women's Health and clinical trials. *The Journal of Clinical investigation*. 112 (7), 973-977.
- Schmidt, L. (2009). Social and psychological consequences of infertility and assisted reproduction. *Human Fertility*. 12 (1), 14-20.
- Selvaratnam, T. (2014). *Motherhood, Feminism, and the reality of the Biological Clock*. London: Prometheus Books.
- Shaw, R. Giles, D. (2009). Motherhood on ice? A media framing analysis of older mothers in the UK news. *Psychology and Health*. 24 (2), 221-236.
- Shelton, N., & Johnson, S. (2006). I think motherhood for me was a bit like a double edged sword: The narratives of older mothers. *Journal of Community & Applied Social Psychology*, 16, 316-330.
- Smajdor, A. (2011). The ethics of IVF over 40. *Maturitas*. 69 (1), 37-49.
- Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative Phenomenological Analysis. Theory, Method and Research*. London: SAGE Publications Ltd.
- Sonfield, A. Hasstedt, K. Kavanaugh, M. Anderson, R. (2013) *The Social and Economic Benefits of Women's Ability to Determine Whether and When to Have Children*, New York: Guttmacher Institute.
- Stand, N. (2002). The importance of pilot studies. *National Institute of health*. 16 (40), 33-36.
- Stoop, D. Cobo, A. Silber, S. (2014). Fertility preservation for age-related fertility decline. *The Lancet*. 384 (9950), p1211-1319.
- Sutcliffe, A. Barnes, J. Belsky, J. Gardiner, J. Melhuish, E. (2012). The Health and development of children born to older mothers in the United Kingdom: Observational study using longitudinal cohort data. *BMJ publishing group*. 34 (5), 1-7.
- Talmore, A. Dunphy, B.. (2015). Female obesity and infertility. *Best Practice Research clinical Obstetrics and Gynaecology*. 29 (4), 449-576.
- Tomao, F. Russo, G. Spinelli, G. Stati, V. Prete, A. Prinzi, N. Sinjar, M. Vici, P. Papa, A. Chiotti, M. Panici, P. Tomao, S. (2014). Fertility Drugs, reproductive strategies and ovarian cancer risk. *Journal of Ovarian Research*. 7 (51), 1-8.
- Ulrich, M. Weatherall, A. (2000). Motherhood and infertility: Viewing Motherhood through the lens of Infertility. *Feminism and Psychology*. 10 (3), 323-336.
- Varada, M. (2011). Infertility, Women and assisted reproduction Technologies: An Exploratory Study in Pune, India. *Indian Journal of Gender Studies*. 18 (1), 1-26.

Wiles, R. (2013). *What are Qualitative Research Ethics*. London: Bloomsbury Publishing.

Wodak, R. Meyer, M. (2009). *Methods for Critical Discourse Analysis*. 2nd ed. London: SAGE publications.

Woollett, A. (1991) 'Having Children: Accounts of Childless Women and Women with Reproductive Problems', in A. Phoenix, A. Woollett and E. Lloyd (eds) *Motherhood. Meanings, Practices and Ideologies*, pp. 47–65. London: Sage

Woollett, A. and Boyle, M. (2000). Editorial Introduction: Reproduction, Women's Lives and Subjectivities. *Feminism & Psychology* 10(3): 307-311.

## Appendix 1: SREP Application form

### THE UNIVERSITY OF HUDDERSFIELD

#### School of Human and Health Sciences – School Research Ethics Panel

#### OUTLINE OF PROPOSAL

Please complete and return via email to:  
Kirsty Thomson SREP Administrator: [hhs\\_srep@hud.ac.uk](mailto:hhs_srep@hud.ac.uk)

Name of applicant: Kirstie Rothwell

Title of study: 'To explore the views and experiences of fertility treatment amongst women over the age of thirty-five'

Department: Research/ Behavioural Sciences

Date sent:

Issue	Please provide sufficient detail for SREP to assess strategies used to address ethical issues in the research proposal
Researcher(s) details	Kirstie Rothwell, student at the University of Huddersfield undertaking this research as part of a Masters
Supervisor details	Abigail Locke  Joanne Garside
Aim / objectives	<p>This qualitative research will explore the views and experiences of some women over 35 who are infertile and thinking about or going through fertility treatments. Semi-structured interviews will be carried out in order to discover why these women are considering/ going through fertility treatments and their views on it. This research will also look into whether or not these women think fertility treatments is easily accessible and whether or not they think there should be an age limit for women who are thinking about having fertility treatment. Finally, this research aims to discover whether or not having a child with help of fertility treatment goes against the 'norm' of motherhood, as some may argue having a child should be 'natural'. Fertility treatment is an under researched area and this study therefore aims to provide valuable research on this topic area which will fill a gap in the research. The aim and objectives of this research is as follows:</p> <p>Aim: To explore the views and experiences of fertility treatment among women over the age of thirty-five</p> <p>Objectives:</p>



Identify any potential conflicts of interest	Not Applicable
<b>Please supply copies of all relevant supporting documentation electronically. If this is not available electronically, please provide explanation and supply hard copy</b>	
Information sheet	The information sheet attached will be given to all the participants prior to the research being carried out.
Consent form	The consent form that is attached will also be given to participants. The interviews will be arranged only when the participant has signed to say they agree that they understand what the study is about and that they wish to take part.
Letters/email	Attached are two example letters that will be sent to potential participants.
Questionnaire	Not Applicable
Interview guide	See attached document
Dissemination of results	The data will be presented in a dissertation/thesis as well as disseminated as conference papers and potentially presented in professional and/or academic journals.
Other issues	n/a
Where application is to be made to NHS Research Ethics Committee / External Agencies	n/a
All documentation has been read by supervisor (where applicable)	Please confirm. This proposal will not be considered unless the supervisor has submitted a report confirming that (s)he has read all documents and supports their submission to SREP

**All documentation must be submitted to the SREP administrator. All proposals will be reviewed by two members of SREP.**

**If you have any queries relating to the completion of this form or any other queries relating to SREP's consideration of this proposal, please contact the SREP administrator (Kirsty Thomson) in the first instance – [hhs\\_srep@hud.ac.uk](mailto:hhs_srep@hud.ac.uk)**

**THE UNIVERSITY OF HUDDERSFIELD**  
**SCHOOL OF HUMAN AND HEALTH SCIENCES – SCHOOL RESEARCH ETHICS PANEL**

**SUPERVISOR REPORT**  
**Please complete and return via email to:**  
**Kirsty Thomson SREP Administrator: [hhs\\_srep@hud.ac.uk](mailto:hhs_srep@hud.ac.uk)**

Name of student: Kirstie Rothwell

Title of study: To explore the views and experiences of fertility treatment amongst women over the age of 35.

Name of course (if not MPhil or PhD) Masters by Research

Name of supervisor(s): Abigail Locke & Joanne Garside

Date: 20/1/15

I confirm that I have (a) read all documentation submitted to SREP in respect of the above research project and (b) support its submission to SREP. I also confirm that a Risk Analysis has been conducted in accordance with University requirements.

Please identify all documents seen below:

Letters (specify)	X email follow up
Participant information sheet	x
Participant consent form	x
Interview schedule	x

Questionnaire	
NHS REC form	
University of Huddersfield Risk Analysis and Management form	x
Other	

Signed (if submitting hard copy): Abigail Locke



**Please note:**

No application submitted by a student will be considered by SREP without a fully completed Supervisor Report

**If you have any queries relating to the completion of this form or need any other information relating to SREP's consideration of this proposal, please email [hhs\\_srep@hud.ac.uk](mailto:hhs_srep@hud.ac.uk)**

### Appendix 3: Email of SREP Approval

sign out | Kirstie Rothwell U1172524 ▾

 **1** ▾  [Find Someone](#) Options ▾ Help ▾

Dear Kirstie,

Dr Dawn Leeming, SREP Deputy Chair, has asked me to contact you with regard to your SREP application as detailed above.

**\*Your application has been approved outright with the following minor but essential amendments to be checked by your Main Supervisor (Abigail):**

**Essential amendments**

- Please confirm that data will not be left in your car boot unattended.
- Your information sheet should be revised to improve clarity and accessibility. Please see attached version of info sheet with comments.
- Please also revise consent form to address a couple of small but important issues of clarity (see attached).

The reviewers also suggested a few further non-essential amendments, to be considered at your and your supervisor's discretion:

**Recommended amendments**

- Interview schedule Q4 Should this be more of an open question? Q.14 - Would suggest that this is broken into 2 parts or separate questions. Is currently worded to imply that they will respond in agreement and believe that there are reasons why women are judged unfavourably. Not a neutral question.
- Please see comments on email to participants attached.

With best wishes for the success of your research project.

Regards,  
Kirsty



## **Information Sheet**

### **Research Project**

**Human and Health Science, 2015**

**Project Title:** 'Fertility treatment among 'older' women: a qualitative review.'

### **What is the study about and who is conducting the research?**

My name is Kirstie Rothwell, and I am a research student studying a Master's degree in Research at the University of Huddersfield. As part of the course I am required to undertake a research project. The topic area of this research is on women who are over the age of thirty five who are considering or undergoing fertility treatment. This project will focus on the women's experiences and opinions towards fertility treatment and motherhood.

### **Why have you been approached?**

You expressed an interest in this research and I feel your views and opinions would be valuable to the study. It is your decision whether you want to take part in this research.

Your signature on the consent form will indicate that:

- You are considering fertility treatment or going through/had fertility treatment
- That you are 35 years or older
- That you are willing to participant

### **What will happen?**

You are invited to participate in this study where I shall be carrying out interviews with women who are all over the age of thirty-five. The interview will give you the opportunity to talk openly about your experiences. The interviews can be over the telephone or in person and will last between 30-60 minutes. All interviews will be digitally recorded for transcription purposes.

### **Your consent and right to withdraw**

You will be asked to sign a form before taking part in the study to show that you are willing to take part in the research. You can change your mind and **withdraw from the study** at any time. You may also skip questions if you feel that you do not wish to answer them and you can do this without providing an explanation to me. At the end of the interview, you will be debriefed by me.

**Will this research ensure confidentiality and anonymity?**

Your participation is your choice and any information that is obtained in connection with this study will remain confidential and secure. Your name will also be removed and replaced with a pseudonym to ensure your details are not displayed and to protect your identity. The data you give will be kept securely at the University of Huddersfield.

**What will happen to the information?**

**The research may, at some point be, be published in a journal or report.** However, should this happen, your anonymity will be ensured, although it may be necessary to use your words in the presentation of the findings and your permission for this is included in the consent form. The information collected will also be kept in secure conditions for a period of five years at the University of Huddersfield.

It is not envisaged that the research will cause distress, however If you require psychological support throughout this research then please contact:

- Your local GP  
Or
- Get in touch with the infertility network UK which can offer professional advice, support and understanding. Call their Helpline on 0900 008 7464 or their support line on 0121 323 5025.

If you require any further information about the research, please contact me or my supervisors on:

Name: Kirstie Rothwell

Email: [Kirstie.Rothwell@hud.ac.uk](mailto:Kirstie.Rothwell@hud.ac.uk)

Name: Abigail Locke (supervisor)

Email: [A.Locke@hud.ac.uk](mailto:A.Locke@hud.ac.uk)

Name: Joanne Garside (supervisor)

Email: [j.garside@hud.ac.uk](mailto:j.garside@hud.ac.uk)



## CONSENT FORM

**Title of Research Project:** 'Fertility treatment among 'older' women: a qualitative review.'

It is important that you read, understand and sign the consent form. Your contribution to this research is entirely voluntary and you are not obliged in any way to participate, if you require any further details please contact your researcher on [Kirstie.Rothwell@hud.ac.uk](mailto:Kirstie.Rothwell@hud.ac.uk)

I have been fully informed of the nature and aims of this research

☐

I consent to taking part in it

☐

I understand that I have the right to withdraw from the research at any time up until the researcher has transcribed the interview, without giving any reason.

☐

I give permission for my words to be quoted (by use of pseudonym)

☐

I understand that the information collected will be kept in secure conditions for a period of five years at the University of Huddersfield

☐

I understand that no person other than the researcher/s and supervisor/s will have access to the information provided ☐

I understand that my identity will be protected by the use of pseudonym in the report and that no written information that could lead to my being identified will be included in any report. ☐

If you are satisfied that you understand the information and are happy to take part in this project please put a tick in the box aligned to each sentence and print and sign below. (can be completed electronically)

Signature of Participant:  _____  Print:  _____  Date:  _____	Signature of Researcher:  _____  Print:  _____  Date:  _____
---	--

(one copy to be retained by You / one copy to be retained by me the researcher)

## Appendix 6: Examples of 'Tweets' used to recruit participants



## **Indicative Interview Guide**

The interview schedule will consist of a semi-structured interview; however the questions I use will fit according to the participant's responses. (Order and Wording may change)

1. Can you tell me a little bit about yourself?
2. What made you decide that you wanted to have children?
3. Can you tell me a little bit about your experiences of trying to have a family?
4. Are fertility treatments something you are thinking about going through or are you currently going through the process of having treatment?
5. Which treatment is it your thinking about/going through and why do you think it is the most appropriate for you?
6. Could you tell me a little bit about the access of fertility treatment and whether or not you think it is easily accessible?
7. Do you think there should be an age limit on fertility treatments and why?
8. In the UK, the age limit to have fertility treatment is 39, what do you think about this?
9. Do you think there is an ideal age to have a baby and why?
10. Could you tell me whether or not you think more women are relying on fertility treatments to get pregnant and why?
11. Could you tell me whether or not you agree with women putting other commitments first and then having fertility treatments to get pregnant?
12. Do you think that fertility treatment is one of the reasons why there has been an increase in older mothers?
13. Do you believe that women are expected to have children?
14. Could you tell me whether or not you think women who don't have children are frowned upon?
15. In connection with the previous question: What are the reasons why you think women who do not have children are judged unfavourably?

Interviewee: Yes, so when we got married we were not, not really trying to have a baby. So we weren't using contraception and we were just seeing how things went. I wouldn't say we were actively trying for a baby but I was off the pill. Then it got to about a year down the line and nothing had happened and then we just thought we may have been unlucky as it can take a long time to get pregnant. Then it got another 6 months down the line and still nothing had happened so I think we sat down and had the conversation that we may need to go to the doctor. So we went to the doctors and we had blood tests and other tests. They said they didn't think there were any particular problems with me but they did think there may have been problems with my

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husband's sperm count and that we may need help to get pregnant. So at that point we were a bit like 'shit' and it became a bit of a shock! Then we went to the hospital and started the IVF.

Interviewer: So how old were you when you had your first child?

Interviewee: I was 32

Interviewer: Was that naturally?

Interviewee: No she was IVF, which was when we had the first round of IVF we had. We were referred in the October and we decided not to start that until after Christmas. So then we started it in January and we were pregnant in the February. We were very lucky actually, as people have multiple rounds of IVF and still don't get pregnant.

Interviewer: yes they do, so was your IVF cycle on the NHS?

Interviewee: Hmm...no it wasn't because when we went to the hospital they said there was a 1 or 2 year waiting list, so we made the decision to pay private.

Interviewer: Right OK, so if you don't mind me asking, could you pay that out of your wages or did you have to get a loan in order to pay it?

Interviewee: No we were able to pay it ourselves.

Interviewer: Sorry I am going to ask another rude question but would you mind telling me how much you paid for that?

Interviewee: I think it was about £5000 in total including all the drugs and everything.

Interviewer: Gosh it is a lot of money isn't it?

Interviewee: Well we had ICSI IVF which is more advanced than normal IVF, so that is more money. Then when they add all the drug costs on and start freezing eggs it gets more expensive. So initially you think it's going to be about £3000 but then you start getting invoices in the post.

Interviewer: So do you have to pay for the treatment up front or can you pay monthly?

Interviewee: no you have to pay it when you have the treatment or have the drugs. I think we had to pay the initial

32 when had first child – through IVF	First child through IVF	
IVF successful first time		
'lucky' as people have multiple rounds	Feelings of luck	Feelings towards success of treatment
Private due to 1 or 2 year waiting list on NHS	IVF private due to waiting lists	Went private due to NHS waiting lists
Able to afford private	Costs and ability to pay	Costs and ability to afford treatment
Cost of treatment	Cost of treatment	Cost of treatment
Cost of treatment increases as you go along with drugs etc	Initial payment is less than actual payment	Cost of treatment
Initial amount paid upfront	Cost and ability to pay	Costs and ability to afford treatment



£3,500 up front and then as we went through the process they were just sending invoices as and when we had extra drugs and things. I think maybe some clinics you can pay monthly but we weren't aware that you could at the hospital we went to. We had to give our credit card details straight away.

Interviewer: Oh gosh. It does sound expensive but then you have your baby so it must not seem that bad. People pay thousands on a car which deteriorates over time, at least with IVF there is a chance it may not work but you may have a child for the rest of your life.

Interviewee: \*Laughs\* That is exactly how we thought of it. It really is the best money we ever spent.

Interviewer: So why IVF? Is it something the doctor recommended or is it something you researched and thought it was best for you?

Interviewee: That is what the doctors told us we needed, so we weren't giving any other options. I think it was very unlikely we would get pregnant naturally so we just went for it.

Interviewer: What did you feel like when they told you that you needed IVF and then the next thing you're having it? Did you know a lot about it or was it something you didn't really know what was involved?

Interviewee: I had worked with 2 or 3 people who had gone through IVF, so I knew quite a bit about it but I guess when it happens to you, you don't realise how intense it can be on your body. I think the worse thing I thought about IVF was that I had to inject myself, so I was scared of that. I thought that my life would change because I would have to take loads of drugs and have lots of time off work and attend lots of hospital appointments. It is always at the back of your mind that it may not work. Hmm...I suppose that even though we paid for the treatment initially, we always thought that we had another chance of the NHS because you can remain on the waiting list whilst you have treatment privately and then if it is unsuccessful you are still eligible to have your free cycle/cycles on the NHS. Then I guess you are always thinking that it might never work and you have to face the reality that you may not ever have a child.

Wanted card details straight away		
'best money ever spent'	Feelings towards cost of treatment	Cost and positive views
Doctors referral - best option		
Intense treatment on body	Feelings of treatment – intense	Negative effects of treatment - feelings
Worse bit was injecting yourself	Negative effects of treatment	Negative to treatment
Life changing	Negatively life changing	Negative effects of treatment
Risk that it may not work		
Rely on NHS treatment as a fall back		
Reality that it may not work and may never have a child	Reality that she may never have a child	Reality that ivf may not work

Interviewer: Yes, you were quite lucky in the sense you got pregnant the first time.

Interviewee: Oh yes, exactly, people go through loads and loads of cycles and they lose babies and they have ectopic pregnancies and I just don't know how people do it. Having gone through 1 cycle...I don't know how people can do it numerous times. My close friend had 3 cycles and 2 of them she lost the baby and I just don't think I could have coped with that.

Interviewer: Different women I have spoken to have obviously had different experiences and some say that it wasn't too bad and others say IVF was horrendous. What did you feel?

Interviewee: I think that when you are injecting the drugs and going to hospital for appointments I don't think you really think about it, but then when you get to the point where you have to wait 2 weeks to find out if you are pregnant or not and I think that is a really hard time and it is the worst point. Up until that time, both me and my husband were both find and we were just going through the motions of it and following what the hospital tells you to do. We started to think about what we would do if it was unsuccessful and whether we would go through IVF again. We also thought about how many times we would go through IVF if every time they didn't work. We had to think about an age or a point in our lives where we would have to give up if we hadn't got a baby. It was a really horrible time those last two weeks because we had stopped taking the drugs and it was just a time where we were talking and over thinking things.

Interviewer: That must be really hard

Interviewee: Yes they say that you have like a 30/33% chance of working each time so we thought well we would try it 3 times altogether so that we know we have had a chance. So yeah it was a really horrible time, especially those last 2 weeks. You have to go into hospital at the end of the 2 weeks and obviously have a blood test and then they make you wait 3 hours to ring you to tell you whether you are pregnant or not. To be honest I had done a pregnancy test two days before that and it said that it was positive but they are looking to see whether it is viable I guess. I remember been at work and I couldn't concentrate on anything. I remember there was a 10 minute window in which you had to ring

Risks of treatment and how people cope	Negative aspects and risks which people go through	Negative/risks of IVF
Horrible having to wait to see if it had been successful		
Going through the motions without really thinking about it	Going through the motions	
Had to think about if it was unsuccessful if we would do it again/how many times we would keep trying and how old we would be when we stopped	Realities of the treatment – numerous rounds/may never work	Realities that it may not work
Overthinking		
33% chance of success – thought they would try it 3 times	Success rates – try 3 times in hope they had a chance	Success rate

between and as soon as it got to that time I was on the phone.

Interviewer: Oh gosh I can't believe they make people wait that long. Some people may have had a test and it may have been negative so they are just waiting for bad news...or hoping that the test they did was wrong.

Interviewee: That is why they tell you to never take a test at home because it may say it is negative but you may be pregnant and it's taking a while to show up. However, I'm sure most people must take a home test because I know I couldn't have waited to find out through the hospital. When it's like 10 days into the 2 weeks it's like impossible not to have a test.

Interviewer: So obviously you are pregnant now, so what did you go through to get pregnant this time?

Interviewee: From the first cycle of IVF we had one embryo left over and we had it frozen and then we got to last summer and then we thought that was going to be 35 soon and I didn't want a massive age gap so we thought we would use the frozen embryo. The process with a frozen embryo is a lot less stressful and it doesn't take as long. My husbands a teacher as well so we decided that it would be best to do it over the summer holidays and it worked.

Interviewer: Gosh that is actually amazing how both times worked for you both.

Interviewee: I mean we were really lucky how both worked.

Interviewer: Was you always planning on using that frozen embryo or was you thinking of trying to have a baby naturally again?

Interviewee: I think my husband's thoughts were different to mine. I think he thought that we should try naturally for a while before we use it. I thought that it wasn't worth wasting time trying naturally when realistically it's not going to happen. Also we had paid for the frozen embryo and we knew that the cost of treatment would be far less than a full fresh cycle. I think I felt a bit of an attachment to it too because I knew we had got my daughter from the last egg and it was good quality and I just felt like we should try again with the frozen egg as we had nothing to lose. If not we

Make you wait to find out – not allowed to take a home test		
Process with frozen embryo is less stressful	Feelings towards frozen cycle – doesn't take as long, less stressful	
One fresh cycle and one frozen - both worked	2 rounds of IVF both successful	Successful cycles
Husbands thoughts were different to hers	Husbands thoughts were different to hers – he wanted to try naturally	Views of both partners were different
Felt attached to the frozen embryo	Feelings of attachment towards frozen embryo	Feelings towards frozen embryo

would have been thinking that it was stuck in the freezer as we are getting older...I know it is only a group of cells but...

Interviewer: Gosh I have never thought about that and the attachment you may have to that embryo

Interviewee: Yes you start to think that it could actually be a baby and in reality that embryo was created at the same time our daughter was conceived, so it is kind of like her twin but born 3 years later. So I think I felt more of an attachment than my husband did and I just took the lead and he followed what I wanted to do.

Interviewer: So when you freeze and embryo, do you have to pay per embryo?

Interviewee: Basically when they put one or two back in you initially, normally you have a few embryos left over. So I think at that time they were monitoring 3 or 4 on their growth but they rung us up and said that there were two that they could potentially freeze but they wanted to keep an eye on them for longer to see...because some of them just rest and don't do anything and they don't last the distance. So it turned out that we just had one really good quality one whereas sometimes people have a few that they freeze but they may not be great quality. But you just pay for the cost of freezing rather than the cost of per embryo. You aren't really given an option as to how many you want to freeze; I think they just recommend the amount they think have a chance in actually working.

Interviewer: So how much is it to freeze an embryo?

Interviewee: I think it was about £500 for us, but I think that depends on the clinic you go to. I think we paid £500 for 3 years.

Interviewer: So you must have been happy with the service, so was your clinic completely private or was it used by both private patients and NHS patients?

Interviewee: It was split and used by both private and NHS patients. All the drug appointments were done at the hospital and then they had a satellite private clinic in Manchester. So when we had all the eggs retrieved and put back it was dealt with at Manchester.

Interviewer: So were you happy with the clinic you went to?

Frozen embryo is like twin of other daughter but born years later	Feelings / attached to frozen embryo	Feelings towards frozen embryo
Pay for cost of freezing rather than per embryo		
Aren't given a choice about the amount of embryos freezed		
Costs of freezing		

Interviewee: Yes I was really happy with the clinic as after all both times they got me pregnant.

Interviewer: What was the access of fertility treatments like when you went down the NHS route to start with?

Interviewee: I think the NHS part was good really. I think the waiting was a pain in the backside so obviously we had to end up paying. I think the way we were dealt with at the clinic was fine and the appointments were always promptly, we never really had to wait to be seen. I didn't really have any issues with them, I thought they were great.

Interviewer: So you said that you decided to go private, rather than wait on the NHS waiting list, which worked and you got pregnant; but did you contemplate waiting on the list for 2 years and then using that opportunity to have a second baby?

Interviewee: You can't. Once you have had a baby through IVF you aren't allowed to use the NHS, whether you had that baby privately or through the NHS. Well in our area, you aren't eligible for NHS funding once you have had a baby through IVF.

Interviewer: So when it is unsuccessful you are allowed though aren't you?

Interviewee: Yeah my friend paid for her first cycle but it didn't work but she was on the NHS waiting list to have it for free and when she rung up she was about 3 months away from being at the top of the list. Once you have had a successful pregnancy you aren't eligible.

Interviewer: When you go for treatment on the NHS what kind of questions do they ask you?

Interviewee: They don't really go into that much detail really; they make you fill in forms. They asked my husband if he had any children from a previous relationship because that would mean we weren't eligible for funding.

Interviewer: I find that so harsh because that isn't your fault and you may never see or have the opportunity to bring that child up.

Interviewee: It is a completely different relationship so I just don't understand it. They make you fill in forms about child

NHS part of private clinic was good. Waiting list was bad	NHS good apart from waiting lists	Waiting lists – negative to NHS
Aren't allowed to use NHS cycle once you have had a baby despite been on the waiting list	Eligibility for NHS funding – one child through ivf or natural stops more funding	Eligibility for NHS funding
Friend paid for first cycle –did not work so was allowed NHS	Can wait on NHS list whilst having treatment private	Eligibility for NHS funding
child from previous relationships – not eligible for funding	Eligibility for funding and existing children	Eligibility for funding
personal questions - access	Access and personal questions	Access and personal questions

protection and whether you have hurt a child. They ask you about drugs and whether you have been in trouble with the police and things like that. So they don't really ask questions about your relationship but they do ask questions on whether you would be suitable to be a mother. They also check that with your doctor and make sure they think you are fit enough to be a mother and that there is no drug use in the past.

Interviewer: Was this the same procedure as when you went to the private clinic?

Interviewee: Yes exactly the same protocol

Interviewer: Was the access to the private clinic easy and how did you choose that particular clinic?

Interviewee: we didn't really choose the clinic because we just went to the most local one. We didn't know we would go to that clinic when we originally had an appointment about IVF because we thought we would have the treatment on the NHS but when they said about the waiting list we looked at the success rate of that clinic and then looked at the one in Manchester, we decided to go to the one we went to because it was good and also local.

Interviewer: Do you believe there is a postcode lottery in terms of getting treatment on the NHS?

Interviewee: Yes definitely, I know that in some areas people are eligible for two or three cycles on the NHS and then others you may not even get any. At least we got one chance for one even though we didn't use it, but I don't think it is fair that it differs so much across areas. It is such an expensive process and we were lucky that we could afford it but there are people out there who can't afford it and would have to get themselves into so much debt to pay for it. I think there should be more consistency in terms of what people get on the NHS and I don't think where they live should matter.

Interviewer: Do you think that poor people are disadvantaged?

Interviewee: Yes I do, I think everybody should have the same right to have a baby. I know that some people wonder why they don't just adopt but when that person can't have a child themselves it is a difficult thing to think about and it depends on how that person feels about it. People who are poor

<p>Suitability to be a mother</p> <p>Check with doctor about the use of drugs etc</p>	<p>Suitability checks during access</p>	<p>Eligibility and access of treatments – suitability tests</p>
<p>Looked at success rates of clinic</p>		
<p>Eligibility for funding – postcode lottery</p> <p>Not fair</p> <p>Expensive process</p> <p>Should be more consistency on cycles</p>	<p>Postcode lottery – funding for nhs cycles</p>	<p>Postcode lottery – not fair</p> <p>Postcode lottery – should be consistency</p> <p>Postcode lottery – ignores people who may not have the money to pay for treatments</p>
<p>Everybody should have the same right to a baby. Poor people should have the same opportunities</p>	<p>Equal opportunities for IVF – poor people should have same opportunities</p>	<p>Equal opportunities for IVF (eligibility)</p>

should have the same opportunities. I am not saying that there should be an infinite number of IVF cycles available on the NHS and that women can just keep trying until they get a baby...no I am not saying that, I just think that everywhere should be equal. I also think that one cycle isn't enough and maybe everybody should be eligible for 2/3 cycles.

Interviewer: So do you think there should be an age limit on fertility treatments?

Interviewee: Yes I think there should be an age limit as I don't agree with somebody over the age of 50 should be having fertility treatments.

Interviewer: Why not?

Interviewee: \*laughs\* I have no idea.

Interviewer: \*laughs\* there must be something why you think that.

Interviewee: I think you have to think of the child and how old the child is going to be when you die. So if you have given birth in your early 20's then you're going to be about 70 when that child is about 18. I just think that when you get to that age it isn't fair because it is very selfish. I don't think you are fit enough to cope with a child when your old anyway.

Interviewer: When you have fertility treatments do they explain that you could potentially have twins or triplets?

Interviewee: Well yeah but when we went to have the embryo back in, they ask you at that point how many you want putting back in. Obviously If you say you want more put back in then the chances of having twins and triplets increase considerably. They recommend that (well because of my age and that it was our first attempt) that we just put one back in. Also they explain the risks of having multiple pregnancies when you go to your consultation.

Interviewer: What did you think about that?

Interviewee: To be honest I didn't really want twins. I was quite happy to only have one put back because I knew it was good quality and therefore it was a high chance that it would work. So I didn't think it was necessary to put more than one back.

Should be an age limit – disagrees with women over 50 having treatment	Women over 50 should not have treatments	Should be an age limit
Risk of leaving child behind – older mothers	Risk of older mothers – leaving children behind	Risks of older mothers
Selfish and not fit to cope	Older mothers – selfish	Older mother are selfish
Chances of twins increase with ivf	Increase chance of twins	Risks of Ivf- twins
Recommend they only put one back		
Risks of multiple pregnancies	Risks of multiple pregnancies	
Didn't want twins - unnecessary		



Interviewer: That is interesting because I don't know if you have seen in the news about the women who has 12 children and had IVF and she's ended up having another 4 children.

Interviewee: God that is ridiculous.

Interviewer: Surely she knew the risks of having a multiple pregnancy?

Interviewee: She must have done. There is always the chance of putting one back in and then it splits and that's when you get identical twins etc. but that is much more rare. In our clinic they say they don't really want their patients to have twins because the pregnancies are much more complicated and cost more money. They have to give birth earlier and I think the risk is just a lot higher. Both me and my husband really didn't want two. I knew people who had twins through IVF and I knew how difficult it is to have twins.

Interviewer: Do you think there is an ideal age to have a baby, whether that is through IVF or naturally?

Interviewee: I don't think there is an ideal age and I think it depends on your circumstances and how stable your relationship and how financially stable you are. I think when was in my 20's I didn't really think about having a baby but when the biological clock is ticking when you're in your 30's I think you do start to think about it. It's always in the papers how women's eggs deteriorate when they are over 30 and I think you become more aware of it. I think anything up to 40 and earlier 40's is fine in terms of having a child. Overall I do think it is down to individual circumstances though.

Interviewer: Can you tell me whether or not you think women are relying on fertility treatments to get pregnant?

Interviewee: I don't think so, I think again it depends on the individual and what they do with their life and when they meet somebody. I can't imagine anybody thinking that they will leave it until they are 30+ and then think they will consider fertility treatment if they can't get pregnant. I don't think people consciously have that thought and I don't think people think about fertility treatments until they physically can't have a child. Life just happens and people get on with their lives and then they think 'god I need to have a baby'.

Interviewer: Do you think more people are aware of fertility treatments and what they have to offer?

Multiple pregnancies are more complicated and cost more money. Risk is a lot higher	Negative to twins	Twins – more complicated, more money and more risks
Age depends on circumstances such as relationship and finances	Ideal age depends on circumstances of individual	Ideal age varies
Biological clock ticking making her think she better try	Biological clock ticking – pressure to have children	Biological clock ticking
More aware of infertility decreasing as you get older	Women are aware of infertility decreasing due to media	Media making women aware of infertility and age
Don't think women consciously have fertility treatments	Women don't consciously have fertility treatment	FT aren't something women want to have – not thought of until necessary
Women more aware of FT and the options	Women more aware of options and FT	Women more aware of options



Interviewee: I think so. I think more people are aware of the options when it isn't working naturally for them and I think that is down to the media and people around them may be going through treatment. People are aware of it, definitely more than they were in the past.

Interviewer: Why do you think that?

Interviewee: I think it is a lot to do with the media? Like when Dolce and Gabbana said IVF babies are synthetic babies.

Interviewer: Oh gosh I read that and it was terrible.

Interviewee: yes I think it was disgusting. There are a lot of things in the paper about the age of the women and fertility treatments. I think a lot is scare mongering. I don't necessary think people know about the details of treatments until they go down the route themselves.

Interviewer: Could you tell me whether you agree or not with women putting other commitments first and then using fertility treatments to get pregnant later in life?

Interviewee: Hmm...no I don't, I just think that there is a natural point in a woman's life where they feel its rights to have a baby. I think women are under a lot of pressure when it comes to juggling a family and career and I think a lot of women choose a career not because they would prefer to have a career, just because at that point in their life they may have felt they were too young and not financially stable to have a child at that age. So I think for some women it is important to build a career before having a baby and I wouldn't say I agree with it because I just think that is the natural thing to do now. Women start to think about a family older than they did when our parents did because women do want to have a good job and be settled into a home but I think that is because the norm has changed so you can't blame the women as that just how life happens.

Interviewer: Do you think women are disadvantaged in the sense that women have a biological clock whereas men can have a baby whatever age?

Interviewee: Yes I think so because women are time limited in terms of when things have to happen. I think there is a lot of pressure of women because they are the ones who have to carry and give birth to the baby. Like you said, I don't think it

More aware than in the past	Media make people more aware of options and FT	Media and making women aware
Media places a big part in spreading the word		
Media focuses on age and FT – scare mongering. People don't know the details until they go through it	Media scare mongers women – focuses on age and infertility	Media is negative when it scare mongers
Women are pressured to juggle family and career.	Women pressures to have family and career	Pressured to have family and career
For some building a career first is right for them and it is natural to do now	Many women choose to have career first as that is the norm now	Women choose career first now – norm
Women are time limited – biological clock	Biological clock limits women	Biological clock/ infertility limits women

is something men think about because they can get somebody pregnant at any time.

Interviewer: Do you think fertility treatment is one of the reasons why there has been an increase in older mothers?

Interviewee: Yes because I think people towards their 40's are having fertility treatments and they have been successful, whereas previously if they tried naturally they probably would have got pregnant. Also I think that people get married later and they are hitting 40's without having a child so they use fertility treatments to get pregnant.

Interviewer: Do you believe women are expected to have children?

Interviewee: I think it depends of the circumstances. I think if you are married or in a long term relationships then I think people expect you to have baby because that is what is seen as the norm in society. Generally there is an expectation for women to have a baby and I think people, especially family can't understand why you wouldn't want a child. There are obviously women who just don't have a desire to have children and it isn't really something they think about it, and people around them don't understand why.

Interviewer: Do you think that expectation has changed over time?

Interviewee: Yes definitely, I think it is becoming more acceptable not to have children now. Before it was kind of frowned upon when people didn't have children but now it is becoming more acceptable than it was previously.

Interviewer: Could you tell me whether women who don't have children are frowned upon?

Interviewee: I think it is based on who is around you and what background you come from. There are some women who will be frowned upon. I think older family members may think it is abnormal to be a woman in your thirties without a child, whereas your friends will think it is just normal as they also don't have children. So I guess it is down to social norms and how they have changed over the years and women aren't prioritising having a family like they used to. I don't think frowned upon is the right word though...I think people would wonder, especially when there is no fertility problems.

FT increase older mothers because they allow women who are unable to get pregnant naturally, to get pregnant	FT increase older women	FT increase older women – more opportunities
People expect women who are married/long term relationship to have a baby – norm in society  Cant understand childfree	Society expects women to have a baby – norm	Expectations – women to have a baby is a norm (especially married women)
More acceptable to be childfree now – was frowned upon – now accepted	Childfree is more acceptable	Childfree is more acceptable than before
Older family members think childfree is abnormal – friends will think it is normal  Social norms changing over time – women aren't prioritising family like they used to.	Older generation disagree with childfree  Social norms changing – womens priorities are changing	Different generations and the norms –  Social norms changing – people think differently  Womens priorities changing

I guess it also goes on how desperate your parents are to be grandparents and things like that.

Interviewer: Do you think a woman's role in society is to have a child?

Interviewee: No

Interviewer: Do you think that was the case in previous years?

Interviewee: I think there was less focus on women being career focus and they were seen as family makers and they stayed at home to look after the children.

Interviewer: How did you juggle work with having IVF?

Interviewee: well it was weird because I had just been made redundant with my job as we were just thinking about having IVF and I was just starting a new job. We did have a conversation about delaying the IVF until I was in the new job in little bit so that it didn't look bad having time off. We kind of had the conversation of whether I would even tell work about the IVF and I decided that I wouldn't tell work because I felt like it would be frowned upon...that I had got the job and then I was going to try and have a baby. So I just made something up that I was having treatment at the hospital and they were quite good generally. It was good because a lot of the appointments were really early in the morning, so I could go to work after those and I didn't really miss a lot of work and if I did I made up the time. I had to have a few days off in the intense part of the treatment but work was really good and they never really asked why. I just booked a couple of day's holiday.

Interviewer: Oh so you chose to have holiday leave rather than sick leave?

Interviewee: There was a point where you are under aesthetic when they do the egg collection and they tell you not to go to work for a few days afterwards and just told work that I had to take some days off sick and they never questioned it. Luckily in the 2 weeks where I was finding out if I was pregnant or not I booked a little bit of holiday and I managed it like that. So altogether I actually only had about 2/3 days off sick.

Interviewer: Oh so you managed to do that quite well.

Womens role isnt to have a child	Disagrees that a womans role is to have a child	women's role is not to have a child
Women were less career focused in the past	Changing norms and priorities	societal norms are changing
New job – didn't tell work about ivf because thought it would be frowned upon		

Interviewee: Yeah they were flexible but I managed it by going to the early morning appointments before work.

Interviewer: So what about this pregnancy?

Interviewee: Well I didn't go back to my old job after maternity leave, as I decided it was going to be too stressful in terms of I worked quite away from home so I didn't think I could manage picking my daughter up from nursery etc. So I decided to do some freelance work and I worked as a freelance worker for about 9 months when I got offered a job which was 2 days a week and I could work from home for a research company in London. So I have 2 days where I have to work over the week and they don't care when I work them as long as I get the work done. It is very easy for me. I have landed on my feet and he lets me get on with it.

Interviewer: That is really good because if things crop up like your daughter being poorly or doctor appointments come up you can choose to work on a different day.

Interviewee: Exactly, that happened this week when my daughter was ill. It is really flexible and I don't know how people work full time with a child.

Interviewer: Right that is the interview finished so thank you very much for taking part, you have said some good things.

Interviewee: You're very welcome, I have enjoyed it actually.

Interviewer: Oh good. Well I wish you good luck in your pregnancy and I hope things go ok.

Interviewee: Thank you very much, Bye.

Interviewer: Bye.

Too stressful to go to back to original job so changed to freelance so that she could juggle work and childcare

## Appendix 9: Example of an initial email sent to participants

To...

CC...

Subject:

To (potential participant)

I am contacting you regarding the research project that you showed interest in through the social media website 'Twitter'. Firstly, I would like to thank you for your enthusiasm to take part in this research, it is very much appreciated. My name is Kirstie Rothwell and this research is part of my studies towards a Master's degree in Research. I will be carrying out the research myself with help and support from my supervisors (Abigail and Joanne) who are academics at the University of Huddersfield. The contact details of my supervisors are given at the bottom of this email. The title of the research is as follows:

### **'Fertility treatment among 'older' women: a qualitative review'**

I have attached two documents to this email which are important for you to read, if you wish to take part in this research. The first is an information sheet which will inform you about the research and what is expected of you. The second is a consent form that you are required to sign that you understand what the research entails and that you wish to take part in the study. Taking part in this research is completely voluntary and you may withdraw your consent at any time during the research, if you wish to do so.

If you could return your consent form as soon as possible, it would be greatly appreciated.

### **What happens next?**

If you would like to participate in this study then please contact me to let me know. I would like to thank you for your continuing support and once you have contacted me, an email will be sent to you regarding a telephone interview.

If you decide that you are no longer willing to take part in this study then I would like to take this opportunity to say thank you for showing interest and no further contact will be made to you regarding this research. However, if you are interested in knowing the results and outcome from this particular research then please do not hesitate to contact me.

If you have any questions regarding this research, please contact me on my student email address, which is: [Kirstie.Rothwell@hud.ac.uk](mailto:Kirstie.Rothwell@hud.ac.uk). Alternatively you can contact my supervisors Abigail on [A.Locke@hud.ac.uk](mailto:A.Locke@hud.ac.uk) or Joanne on [j.garside@hud.ac.uk](mailto:j.garside@hud.ac.uk)

Best Wishes

Kirstie

Appendix 10: Example of second email sent to those who continued their participation

To...

CC...

Subject:

To (potential participant)

Firstly, I would like to thank you for giving your consent to take part in the research, your opinions and experiences are greatly valued. The next stage of the research process is to carry out the telephone interview. As you are aware, the interviews will take approximately 30-60 minutes and will be digitally recorded. I will have specific questions that I would like to ask you during the interview, but there will be a chance for you to express your views and opinions freely if you wish to do so. In order to carry out the telephone interview I will need your telephone number, however this will be kept confidential and you will not be contacted for any other reason but to be interviewed.

Would carrying out the interview on the 2<sup>nd</sup> of February at 13:00pm be convenient for you?

If you have any other questions regarding the interview process then please do not hesitate to contact me on my email address [Kirstie.Rothwell@hud.ac.uk](mailto:Kirstie.Rothwell@hud.ac.uk) or my supervisors Abigail on [A.Locke@hud.ac.uk](mailto:A.Locke@hud.ac.uk) or Joanne on [j.garside@hud.ac.uk](mailto:j.garside@hud.ac.uk)

Best Wishes

Kirstie Rothwell